SECTION 1: NEEDS ASSESSMENT AND IDENTIFICATION OF THE STATE'S TARGETED AT-RISK COMMUNITIES

Selection of Targeted Communities

The North Carolina Maternal, Infant, and Early Childhood Home Visiting Program (NC-MIECHV) will serve seven targeted communities of need in the state. North Carolina underwent an RFA process in April 2011 to identify the targeted communities we proposed to serve through the MICEHV FY 2010 formula grant funding. The RFA was issued to all 100 counties in the state from the Children and Youth Branch in the Women's and Children's Health Section, Division of Public Health (DPH) seeking local agencies interested in implementing evidence-based home visiting programs with model fidelity in a specified geographic area. To comply with Federal guidance that requires a subset of high-need counties be identified, North Carolina used indicators described in the HRSA Funding Opportunity Announcement (FOA) in combination with other county specific data to identify the 30 counties with the highest need. These 30 counties were considered categorically eligible to respond to the RFA. Groups formed of multiple counties were considered categorically eligible if their combined need indicators would place them within the group of 30 categorically eligible counties. The remaining 70 counties that did not meet the need criteria were also allowed to apply for this RFA if they could demonstrate a comparable level of need for a specific sub-geographical area in the county. No more than one application per identified geographical area was accepted.

NC DPH received 24 applications. Reviewers selected eight applications to consider in the second phase of review. In the second phase of review, a team including DPH staff and consultants from the National Implementation Research Network (NIRN) conducted site visits. Following this second phase of review, a selection committee convened and came to consensus on five initial programs to fund for FY 2010. Additional formula grant monies in FY 2011 permit DPH to expand this funding to support an additional two programs, as noted below.

Targeted Communities Selected:

County/Counties	Lead Agency	Proposed EBHV Model	Initial Budget	Funding Cycle
Buncombe County zip codes 28715, 28748, 28801, 28803, and 28806	Buncombe County Department of Health	Nurse-Family Partnership	$109,018	FY 2010
Lesser **Burke** County (excluding pockets of affluence in identified neighborhoods)	Barium Springs Home for Children	Healthy Families America	$292,105	FY 2011
Northeast Central **Durham** zone (a 120 block area) in Durham County	Child and Parent Support Services doing business as Center for Child and Family Health	Healthy Families America	$342,752	FY 2010
Gaston County (38 census tracts)	Gaston County Health Department	Nurse-Family Partnership	$410,593	FY 2010
Northampton, Hertford, Halifax and Edgecombe Counties	Northampton County Health Department	Nurse-Family Partnership	$437,676	FY 2010
Robeson and Columbus Counties	Robeson County Health Department	Nurse-Family Partnership	$414,990	FY 2011
Yancey and Mitchell Counties	Toe River Health District	Healthy Families America	$263,179	FY 2010

A summary of the seven targeted communities' needs assessments and existing resources follows.

Needs Assessment

Buncombe

Buncombe County has a population of more than 230,000 people with 1,530 Medicaid births in 2009. Of these births, 534 or 35% were first time moms. Approximately 14% of all residents are living at or below the poverty level. Currently, 65% of all births are to women with Medicaid. 51.3% of first time Medicaid mothers reside in the city limits and 41.4% reside in the western section of the county. A significant racial disparity exists in Buncombe County infant deaths: Black babies are almost twice as likely to die as are white babies. The 2004-2008 infant death rate for Buncombe County whites is 5.9 compared to 11.3 for blacks and the 2004-2008 low birth weight rate for whites was 8.4 and for blacks was 14.2 (NC Vital Statistics).

Nurse-Family Partnership (NFP) has been implemented in the county successfully since October 2009 and is currently serving 100 first time low income women. Buncombe County Department of Health (BCDH) has 78 women qualified for NFP this fiscal year who have not been able to be enrolled since the program is full. BCDH is requesting one additional NFP nurse to build capacity to serve an additional 25 women for a total of 125 women in Buncombe County. BCDH has aligned itself with key partners willing to refer and support NFP. The NFP Advisory Committee meetings and agency Leadership Team meetings serve as vehicles to assist in the referral process. All referrals are centralized through the Pregnancy Care Management risk assessment. Additionally, NFP receives referrals from the Mission Hospitals, MAHEC Family and MAHEC Women's Health Center, WIC, School Nurses, walk-in service for pregnancy testing, and all the major obstetric providers in Buncombe County.

Buncombe County is fortunate to have a community with a broad array of organizations serving the needs of children who coordinate services in support of families. Families who are not followed through the Neonatal follow-up or NFP are offered Care Coordination for Children (formerly Child Service Coordination) through BCDH. Buncombe County has an Interagency Management Team (IMT) that provides agency leadership around child health issues in this county. IMT agencies include DSS, Department of Juvenile Justice, BCDH, both school systems, all major mental health agency representatives, Western Highlands (our local management entity), and Community Care of Western North Carolina. BCDH NFP has established a strong network of supportive resources from these agencies to support families as they transition out of NFP.

Burke County

While Burke County was not included in the 30 categorically eligible counties, there is a significant portion of the county in which the need for home visiting services is as great as, or greater than, many of the categorically eligible counties referred to as the "Lesser Burke Geographical Catchment Area." There is not a clean way to define a sub-county area that does not eliminate a large number of families who would benefit from home visiting services; however, there are pockets of affluence throughout the county that are easily identified. As such the Lesser Burke Geographic Catchment Area is defined as Burke County minus the identified

pockets of affluence. Those affluent areas are defined as neighborhoods and subdivisions where the average home prices are greater than $150,000.00.

Within Burke County, sub-county data for risk indicators are not available. However, county-level data indicates significant need for improvement in maternal and child health. Burke County has high rates of infant mortality, domestic violence, and poverty. The county has the 10th highest unemployment rate in North Carolina (14.52%). More than 21% of children were living below the poverty level in Burke in 2009. Local school officials reported 60% of the children enrolled in 2010 qualified for income-based free/reduced-price lunch. In 2009, 64.05% of the total 970 births were Medicaid eligible which is higher than the NC state rate of 51.7% and higher than comparable peer counties' average of 59.8%. Rates of prenatal care entry are low.

Additional MIECHV funds will support the expansion of the Catawba Valley Healthy Families (CVHF) program, a program of Barium Springs Home for Children and an accredited Healthy Families America (HFA) site. To identify Burke's first-time parents with the most intensive needs, referring workers throughout the county have been trained to screen families based on stress indicators by the Catawba Valley Healthy Families Program Director. Burke County Health Department and Blue Ridge Health Care make the majority of referrals; referrals are also made by local obstetrics practices, the Department of Social Services, Burke County Public Schools, local counseling agencies, the CDSA, and pediatrics practices. Through CVHF's partnership with Medical Heights Ob/Gyn, a screen/referral form was developed that is now used as a universal screen/ referral form for medical providers, DSS, Child Care Connections, and other referring sources. CVHF convenes a Referral Process Workgroup now known as the Burke Perinatal Support Collaborative (BPSC) charged with the task of more fully developing a referral process for Burke County pre-birth to five families. The group has been meeting regularly since 2006 and has gradually added new needed members.

CVHF is an established program successfully engaging its target population, resulting in solid outcomes for children and families some of which have been documented in published research. (1) CVHF is well integrated into Burke's early childhood system, and a leader in the County in facilitating successful collaborations to ensure the best use of limited resources. CVHF is governed by its Advisory Committee of collaborative partners whose primary function is advising in planning, implementation, and evaluation of program related activities. Additionally, CVHF will work to recruit representatives from Mental Health, Head Start, and Smart Start. Further, regarding the "local capacity to integrate the proposed home visiting services into an early childhood system," stakeholders have expressed a desire for expanded CVHF services since the program's inception. CVHF has conducted annual Parent, Consumer, and Staff Satisfaction Surveys soliciting feedback from all parents served, all referring workers, funders, and those within our community with whom we routinely collaborate to provide services to vulnerable children and families. Annual surveys routinely document need for expanded services to adequately meet the need of our target population in our community.

Durham

The East Durham Children's Initiative (EDCI) operates within the well-established East Durham neighborhood and consists of a 120-block contiguous area (1.2 square miles) east of downtown Durham. The EDCI population of 7,888 has approximately 200 births each year. The

neighborhood is 70% African American, 20% Hispanic, and 10% other ethnic groups; there are high levels of crime, teen pregnancy, poverty, dropout rate, family violence, and lack of school readiness. Based on the Harlem Children's Zone model, the EDCI project has created a vision of a "pipeline of services," beginning with intense services for the 0-5 population in this neighborhood. EDCI will achieve this milestone through several interventions designed to improve child-rearing strategies, stabilize families, and promote understanding of baby and toddler development.

There are two home visiting programs currently operating in Durham: Healthy Families Durham and an Early Head Start home-based program. At present, there are several mechanisms for referring families to the home visiting program. *Durham Connects*, a program run collaboratively by Durham County Health Department, the Center for Child and Family Policy, and the Center for Child and Family Health, provides screening and referrals to the existing *Healthy Families Durham* program in Durham, including the EDCI neighborhood. *Durham Connects* is a universal, nurse home visiting program designed to address maternal and infant needs immediately following discharge from the birthing hospital. *Durham Connects* provides up to three nurse home visits following birth and continuing to approximately ten weeks of age and has an approximate 69% penetration rate of actual home visits for all births in the county. Two secondary methods of screening and identifying families are active: Pregnancy Care Managers and social workers at Duke Primary Children's Care and Lincoln Community Health Center screen and refer families. This multi method referral system assures that high risk families, across socioeconomic groups, are likely to be identified and referred to the home visiting program proposed here.

Though there are two home visiting programs in Durham, capacity is limited and, at present, cannot address the needs in the EDCI neighborhood. *Healthy Families Durham*'s present funding sources have limited services to first-time parents only, and the program is already at capacity. The Early Head Start home-based program is completely full at present, has very little client turnover, and has a waiting list. In order to increase capacity in the EDCI neighborhood, we are proposing to expand *Healthy Families Durham*, referred to as *Healthy Families East Durham*, to serve an additional 45 families and not just first-time parents in this high need target area.

Healthy Families East Durham is supported by extensive collaboration in the community, including health, mental health, substance abuse, domestic violence and social service partners. Previous research studies conducted by the Center for Child and Family Health have required the creation of agreements around data collection issues with Durham Department of Social Services and Duke Community Health. These agreements will serve as the springboard for partnerships necessary to gather the benchmark data required for this grant. Letters of support from community stakeholders were enumerated in the NC MIECHV State Plan.

Gaston

The Gaston County Health Department (GCHD) provides low-income women with high- and low-risk obstetric care and delivery services. In spite of delivery of support to this population, in 2009, Gaston County's Infant Mortality Rate was 10.3, as compared to the state rate of 7.9. (2) Significant racial and ethnic health disparities are evident in the county's pre-term and low birth

weight rates, as well as the infant mortality rate; in 2009, Gaston County's infant mortality rate was 25.6 for all minority groups, in comparison with the white population's rate of 6.1. Gaston County also experiences high rates of teen pregnancy, late entry to prenatal care, and smoking during pregnancy. Gaston County has a large population of long-term unemployed and underemployed residents. GCHD is uniquely positioned to implement NFP as Gaston County's largest obstetrical practice (42% of all births in 2010).

There is currently one existing home visiting program, the Post-partum Newborn Home Visiting program. There are currently no mechanisms for collaboratively screening, identifying, and referring clients among the six programs that serve low-income mothers in Gaston County: (1) PAT; (2) Care Coordination for Children Program; (3) Pregnancy Medical Home Program; (4) Healthy Beginnings; (5) Post-partum Newborn Home Visiting; and, (5) Adolescent Parenting Program. Each program uses its own networks to find, screen, and enroll clients. In January 2011, staff from these programs and Community Health Partners (CHP) endorsed NFP, and agreed for it to have "first pick" to enroll clients, given its strict enrollment criteria. The Pregnancy Medical Home Program and Care Coordination for Children Program will defer care management activities to NFP for women and children in its care. Each of the cited agencies will sign a Memorandum of Understanding confirming its commitment to a centralized referral system. The existing PAT program will collaborate with GCHD to fully integrate this home visiting program with NFP and our county's other maternal and child service programs. GCHD will expand its Healthy Beginnings Advisory Board to become the Healthy Beginnings /NFP Community Advisory Board, as both programs address the needs of low-income mothers and their children. With plans for a centralized intake/referral system by organizations that offer maternity and early childhood programs, the articulated support of health, medical, and human service agencies, and a joint Healthy Beginnings / NFP Community Advisory Board, GCHD has the capacity to successfully develop an integrated early childhood system.

Northampton, Halifax, Hertford and Edgecombe

The project area consists of four contiguous counties (Edgecombe, Halifax, Hertford, and Northampton) in the northeastern region of the state. The four counties had a total population of 149,854 residents in 2009. The non-white population, including Latinos, is now a growing majority. Unemployment rates in the project area are high in comparison to the state as a whole; both Edgecombe and Halifax were among the 25 worst counties in NC for unemployment. Approximately a third of all children in this region experience poverty as compared to less than a quarter at the state level. These counties struggle with higher rates of child abuse and neglect, school drop out, and poor birth outcomes (low birth weight and infant mortality) than North Carolina as a state.

These four counties have a long history of working collaboratively with their partners to address and develop creative solutions to many of the challenges faced by their respective populations. One home visiting program currently operates in these counties, PAT, with support from non-home visiting programs, the Incredible Years, and Early Head Start. PAT is provided by the Choanoke Area Development Association in Hertford County and by Edgecombe County Schools for tier families. Approximately 215 families are being served in Edgecombe, Northampton and Hertford counties. Incredible Years Parent Training Program is offered to families who have children ages 3-5. Approximately 350 families are served in Edgecombe

County by the Down East Partnership for Children, along with More at Four (the local Smart Start agency). Early Head Start (EHS) is delivered under the auspices of CADA, does not have a home-visiting component, and is currently serving a total of 86 children representing 75 families in Halifax, Hertford and Northampton counties.

All four Health Departments use the mandated state provided forms and screening tools to screen and refer pregnant women and young children.. Upon implementation of the NFP Program, this process will become even more consistent across the four counties as fidelity measures are put into operation. Several additional service organizations and practitioners will serve as referral sources, including local obstetricians and hospitals, county Departments of Social Services and the school system. Media campaigns using local newspapers and radio stations will also be implemented to reach the underserved target audience. All materials will also be translated into Spanish to reach the Latino seasonal migrant farm workers.

Each of the four counties has several components necessary to develop a coordinated early childhood system. The Local Partnership for Children in each county is responsible for developing a comprehensive community-based early childhood system with a goal of strengthening families and ensuring that young children are healthy and ready to succeed when they enter kindergarten. Also, each Health Department has developed its own system to coordinate care for pregnant mothers and young children to ensure access to the appropriate services and supports. The four counties have participated in cross-county collaborative processes previously. Furthermore, once funding is confirmed, a Community Advisory Board will be established to act as the governance body for the proposed initiative.

Robeson and Columbus

Robeson and Columbus counties are located in southeastern North Carolina, and struggle with persistent maternal and child health and socioeconomic disparities. These counties are unique in their racial and ethnic minority populations: over 70% of Robeson's 130,000 member population is comprised of minorities; approximately 40% of Columbus residents are minority. In 2009, there were 2,522 total births in Robeson County, with 1,677 to Medicaid recipients and 498 to mothers ages less than 20. (3) Columbus County had a total of 686 births in 2009; 72.85% of these births were to Medicaid recipients. Robeson and Columbus counties experience high rates of poverty, low-birth weight infants, infant mortality, child fatalities and smoking. A high percentage of residents live in poverty; 76.6% of children less than 12 months of age in the two counties are enrolled in Medicaid and received WIC Program services. Both counties have high rates of teen pregnancy: in 2009, Robeson's annual teen pregnancy rate was currently is second for total teen pregnancies in NC, and Columbus 13th. (4)

Robeson County is currently served by several home visiting programs. NFP has been implemented in Robeson County since February 2009. As of February 2009, 100 clients were enrolled in this program. Funded by Smart Start, PAT is a home-school-community partnership that begins at birth and continues through age five, serving an average of 35 families annually. Additionally, since 1995, the RCHD has provided public health nurse services in the home for a follow-up visit for mothers and infants upon discharge from the hospital. In July 2007, the program was expanded using Smart Start grant funds to include non-Medicaid mother/babies. The program delivered health, social support, and/ or educational services to 420 families in

2010. The county is also served by LRDA Headstart, who served 231 children in 2009. While Columbus County Health Department collaborates and provides integral support for several early childhood programs, including Head Start, there is no home visiting program currently serving this community.

Meetings have been held for potential referral resources as well as for existing referral sources. Current and existing mechanisms for referrals of pregnant women to the NFP program in Robeson and Columbus Counties include the RCHD and Columbus County Health Department clinics, Pregnancy Care Managers, WIC and Community Advisory Board members who are visible leaders in the community. Additional referral sources for NFP include other health and early childhood service providers in both counties. These agencies and practices were oriented to NFP at community stakeholder meetings and have expressed support for the initiative.

Robeson will graduate the first NFP cohort of families beginning in June, 2011. Collaboration and coordination of programs in the county are ongoing. Programs work collaboratively for referral to all services within the county. The proposed NFP expansion will build on these existing relationships and expand them to include Columbus County Health Department's existing community alliances.

Yancey and Mitchell

Yancey and Mitchell county are located in the rural mountains of Western North Carolina. Transportation infrastructure and economic resources are limited; the counties have experienced extensive job losses. Unemployment rates exceed state rates and remain in the double digits. Approximately a quarter of all children in the two counties live in poverty; over half of all children are enrolled in free or reduced price school meals. (5) Local maternal smoking rates (Mitchell, 26.3%; Yancey, 20.3%) are higher than the state average (11.9). (6) Children in Mitchell and Yancey counties suffer health disparities in access to health and medical care, health insurance coverage and dental services.

While Mitchell and Yancey counties possess a high level of need for a coordinated, integrated home visiting service, both communities have significant strengths and resources to build upon, including early childhood education programs and domestic violence programs. Unfortunately, the primary family support services available in Mitchell and Yancey counties are agency-based and reach a limited number of needy children and families who are willing to seek them out. There are currently no intensive home based services available to high risk families.

Pregnancy Care Management (PCM) and Care Coordination for Children (CC4C) will serve as primary referral sources for families. The system of family support and case management in Yancey and Mitchell Counties, as elsewhere is extensive and fragmented with some families receiving extensive services and some few or none. The leadership team of the MY HFA project will take responsibility for keeping all stakeholders informed of service and assuring that HFA home visitors have access to all appropriate referral sources. PCM and CC4C care managers and HFA home visitors will act as a team to decide which families will be assigned to HFA to avoid duplication of services.

Local and State capacity

Local capacities to integrate the home visiting services into an early childhood system are addressed in each local profile above. At the state level, North Carolina has strong leadership and a variety of efforts currently in place to expand a coordinated early childhood system. State capacity to support MIECHV is detailed in the NC MIECHV Updated State Plan; a summary is below.

Strong leadership exists in North Carolina to support the continued development of an early childhood system. In 2010, the Governor's office established North Carolina's Early Childhood Advisory Council (ECAC) to be a comprehensive initiative designed to address the whole early childhood system rather than a subcomponent of the system. The Governor has called upon the North Carolina ECAC to lead the state in creating and sustaining a shared vision for young children and a comprehensive, integrated system of high quality early care and education, family strengthening, and health services that support ready children, families, and communities.

The Alliance for Evidence Based Family Strengthening Programs (Alliance) funds the infrastructure or "scaffolding" needed to support quality implementation of evidence-based programs. This scaffolding may include technical assistance with organizational and community readiness, model fidelity, quality service delivery, and program evaluation. At this time, the Alliance is collaboratively funding program implementation and scaffolding for Nurse-Family Partnership, Incredible Years Parenting Programs, and Strengthening Families.

In September 2005, the North Carolina Institute of Medicine (IOM) Task Force on Child Abuse Prevention named the North Carolina Division of Public Health as the state level agency responsible for the development and implementation of primary child maltreatment prevention efforts. The Division received a recurring state appropriation to fund a Director to carry out these activities.

Identified At-Risk Communities

The following communities were identified as being at risk in the State's initial needs assessment but not selected for implementation of the NC MIECHV due to limitations of available FY 2010 and FY 2011 funding:

Alamance
Anson
Beaufort
Bladen
Cherokee
Duplin
Graham
Greene
Lee
Lenoir
Martin
McDowell
Montgomery
Nash
Randolph
Richmond
Rockingham
Scotland
Swain
Vance
Warren
Washington
Wilson

SECTION 2: NORTH CAROLINA HOME VISITING PROGRAM'S GOALS AND OBJECTIVES

Goal:
Coordinate an effective statewide planning and implementation system through a strong alliance with key partners in early childhood services at the State and local levels that ensures all children grow up in environments that are safe and supportive, and that maximally promote each child's physical, emotional, cognitive and behavioral health.

Objective 1: Utilize the Governor's Early Childhood Advisory Council (ECAC) and other partnerships to optimize strong and effective leadership, coordination and implementation of the NC MIECHV Program at both the State and the local levels.

Strategies:

1.1 Provide updates to the Governor's Senior Policy Advisor for Early Childhood at each phase of the planning, writing and submission of the NC MIECHV Program. Key partners at the State and local levels will provide input to the ECAC's Strategic Plan for Early Childhood being developed by the Council. Early childhood partners have deep content expertise in many of the issues that the ECAC will consider and that expertise can be used to ensure that the plan created by the ECAC builds on existing systems and allows for transformative next steps in building an effective early childhood system. The ECAC will serve as an oversight committee for NC MIECHV.

1.2 Continue to utilize the Early Childhood Comprehensive Grant (ECCS) which resides in the Division of Public Health, Children and Youth Branch as a method to move the early childhood system improvement agenda forward by: (1) working collaboratively with the Governor's Senior Policy Advisor for Early Childhood to align the goals and resources of the ECCS grant with the goals and resources of North Carolina's Early Childhood Advisory Council (ECAC); (2) facilitating progress toward a comprehensive early childhood plan for North Carolina; (3) advancing the young child mental health/social emotional agenda; (4) strengthening the commitment to using developmental science and implementation science to guide all early childhood system building efforts; and (5) continuing to support the goals of the early child care education system.

1.3 Continue to involve the Alliance for Strengthening Families to contribute to and support the NC MIECHV Program. A public-private partnership of funders of early childhood initiatives, the Alliance For Evidence-Based Family Strengthening Programs, was established to coordinate planning and family focused interventions. The group is composed of the funders for the current eight NFP programs in NC and funders of the evidence based parenting programs:

- The Duke Endowment,
- Kate B. Reynolds Foundation,
- Blue Cross Blue Shield,
- The Division of Public Health, Children and Youth Branch,
- The Division of Mental Health/DD/Substance Abuse Services,
- The Division of Social Services,
- Head Start,
- The Department of Juvenile Justice,

- The NC Partnership for Children,
- Duke University, and
- Prevent Child Abuse NC.

At least three members of the Alliance have been named as members of the Governor's Early Childhood Advisory Council which assures a formal pathway of communication between the two groups.

1.4 In conjunction with early childhood experts, recommend key policy change priorities and collective action steps.

Objective 2: Educate communities, policy makers and families on the goals and objectives of the NC Home Visiting Program during the initial phase of planning utilizing a public health approach.

Strategies:

2.1 Create a continuum of training, education, & ongoing professional development.
2.2 Encourage and support local coalition sponsored advocacy activities.
2.3 Serve as a centralized source for exchange of information, technical assistance and resource coordination.
2.4 Present at least four educational sessions monthly to educate community members.
2.5 Increase the supply of qualified professionals.
2.6 Involve families in education and training to increase family awareness of and utilization of available services and supports.

Objective 3: Implement a strong support network to assist local community service providers with implementation of evidence based home visiting models adhering to fidelity requirements

Strategies

3.1 Through the HV funding, expand and sustain state and community public-private entities to consistently guide early childhood initiatives and provide resources, technical assistance, and accountability.
3.2 Promote a high quality workforce providing services for young children and families.
3.3 Identify and create opportunities for advocacy and coordination/action at the regional, national and local levels.
3.4 Promote effective and efficient funding strategies and policies.
3.5 Increase provider awareness of how to work best with local home visiting services and parent education programs.
3.6 Taking best practice methods from Triple P, adopt uniform messages across agencies, disciplines, and organizations.
3.7 Assure that State budget and policies reflect & support key system goals.

Objective 4:: Increase the capacity of local partnerships working to coordinate, improve, and expand delivery of early childhood programs and services.

Strategies

4.1 Contract with the National Implementation and Research Network (NIRN) to provide implementation guidance and capacity building strategies for sustainability at the sites

chosen to implement the HV programs. Through working with NIRN, State and local participants will increase their capacity to coordinate, improve, and expand delivery of early childhood programs and services.

4.2 Increase access for all families to quality information and supportive services.
4.3 Create local leadership coalitions at the community level.
4.4 Create learning communities to share best practices and resources.
4.5 Increase early intervention, perinatal depression, and substance abuse. treatment services.
4.6 Promote healthy behaviors among all pregnant women and young children to facilitate information-sharing & referrals across disciplines & systems.
4.7 Increase diverse parent representation on local and state-level coalitions and planning.
4.8 Explore policy changes to expand Medicaid eligibility for children and pregnant women.

Objective 5: Improve coordination of services for at-risk communities.

Strategies

5.1 Increase access for all families to quality information and supportive services
5.2 Promote collaborative strategies for the most effective governance and leadership among agencies and organizations. Establish working group of senior leaders of relevant agencies and organizations
5.3 Align and integrate service deliveries across agencies and organizations
5.4 Educate parents about high quality early care and education as a support for school readiness
5.5 Increase use of strategies to promote and sustain parental and family involvement
5.6 Increase number of eligible families enrolled in evidence based home visitation programs
5.7 Increase number of families providing a safe home environment

Objective 6: Ensure accountability with program standards and measurement mechanisms to track identified outcome indicators.

Strategies

6.1 Work with National Offices of NFP and HFA and Social Solutions to create and support a data system that effectively tracks and measures child outcomes identified by the grantor.
6.2 Support local strategic plans to meet identified needs aligned with State and Federal priorities.
6.3 Assure that HV programs are utilizing appropriate assessment instruments and outcome indicators to measure progress of the implementation sites.
6.4 Increase the quality of parenting support programs.
6.5 Increase data linkages and information sharing among all partners and agencies.

SECTION 3: SELECTION OF PROPOSED HOME VISITING MODEL(S) AND EXPLANATION OF HOW THE MODEL(S) MEET THE NEEDS OF THE TARGETED COMMUNITY(IES)

(a) Selection of Approved Evidence-Based Home Visitation Models

The NC MIECHV *State Needs Assessment*, completed in September 2010, cataloged and described a variety of home visiting models and programs implemented in North Carolina including four that meet the criteria for evidence based: Early Head Start Home Based Option (EHS/HBO), Healthy Families America (HFA), Nurse-Family Partnership (NFP) and Parents As Teachers (PAT).

In preparation for completion of the final state plan for the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), the NC Division of Public Health, in tandem with our stakeholder advisory committee, used our *State Needs Assessment* to identify the highest-risk communities based on thirteen indicators. We then examined to what degree existing home visitation programs were successfully addressing community needs based on the risk indicators and the State's goals for prevention, as well as the level of national or state support currently available from the model developers or purveyors and what is needed for expansion. Once the evidence-based criteria guidance was issued by HRSA and ACF through the Home Visiting Evidence of Effectiveness (HomVEE) study**,** we reviewed the findings on the seven home visitation models which met the evidentiary standards outlined in HomVEE. We looked at favorable outcomes (primary and secondary) in each domain as well as the outcome relevance to the required benchmarks, and the sustained effects for each of the seven evidence-based models. Attention was also given to the unfavorable or ambiguous outcomes.

Following these steps, North Carolina elected to focus the MIECHV formula grant to expand or enhance EHS/HBO, HFA, NFP and PAT. One of our goals for the MIECHV funding opportunity is to strengthen our state's continuum of evidenced based home visitation programs that meets the level and intensity of the needs of high risk families; the four models were chosen to achieve this purpose for several reasons. First, while there was variance in the level, design and rigor of studies used to determine their effectiveness, as well as variations in desired outcomes, in order to address the unmet needs in our highest risk communities, it was concluded that we must use this funding opportunity to allow local communities to develop a continuum of home visiting models as no one program model can meet the diverse needs of our at-risk communities. Secondly, because of the significant investments already made in the aforementioned home visitation programs at the State and local levels it behooves us, as a State, to build upon and enhance models already in operation as opposed to adding additional models. Finally, the State wants to focus resources to provide the required level of scaffolding to support communities with quality implementation and model adherence.

Based on recommendations from our stakeholders, North Carolina elected to use a competitive process (RFA) for the selection of the at-risk communities to provide evidence-based home visiting services and consequently the actual models that will be implemented. In their applications, communities proposed which of the aforementioned model or models would meet the unique needs of their community. North Carolina requested and received written approval from the model developers and/or purveyors of EHS/HBO, HFA, NFP and PAT. For MIECHV

FY 2011, North Carolina will continue to support the initial five communities selected in the RFA process, in addition to supporting two other sites identified through the initial RFA process as having strong applications but for whom there were inadequate funds in FY 2010.

At-Risk Community	**Model Selected by the Community Based on Needs Assessment**
Buncombe County Zip Codes 28715, 28748, 28803 and 28806	Nurse-Family Partnership –Expansion
East Durham County (a 120-block contiguous area east of downtown Durham)	Healthy Families America- Parents As Teachers – Expansion
Gaston County 38 Census Tracks	Nurse-Family Partnership –Start Up
Northeast Collaborative: Edgecombe, Halifax, Hertford and Northampton Counties	Nurse-Family Partnership – Start Up
Mitchell and Yancey Counties	Healthy Families America – Start Up
FY 2011	
Lesser **Burke** County (excluding pockets of affluence in identified neighborhoods)	Healthy Families America –Expansion
Robeson and Columbus Counties	Nurse-Family Partnership – Expansion

Based on the selection process outlined above, North Carolina will implement *Healthy Families America*, an integrated *Healthy Families America and Parents As Teachers* program, and *Nurse-Family Partnership* in the seven targeted communities. These programs meet the evidence-based criteria and are included in Appendix B of the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

Discussion of Selected Models

As our State's competitive process selected three of the four proposed models, we will limit discussion in this section to HFA, NFP, and PAT. Communities newly identified for MIECHV FY 2011 are identified below, in addition to a summary of those selected for FY 2010 funding.

Nurse-Family Partnership

Fit with Selected At-Risk Communities

The HomVEE study found NFP to have the most favorable impacts with 23 primary outcomes and 41 secondary outcomes of the reviewed models. (7) NFP will be newly implemented in seven at-risk communities (Edgecombe, Gaston, Halifax, Hertford, and Northampton and Columbus Counties) and expanded in targeted high risk areas in Buncombe and Robeson Counties. The proposed expansion of Robeson County's NFP was not included in North Carolina's State Plan for MIECHV FY 2010 funds; additional funds in FY 2011 now allow us to support this program.

Robeson and Columbus Counties: Robeson and Columbus counties are located in southeastern North Carolina, and struggle with persistent health and socioeconomic disparities. The counties experience high rates of low-birth weight infants, infant mortality, child fatalities and smoking.

Model Selection: Robeson County chooses to expand their current NFP program to serve additional Robeson County residents and residents of Columbus County. NFP was selected as

the intensive home visiting program model for these counties as NFP has been found effective for target populations (low income African-American, Caucasian, and Hispanic women/teens) and in rural communities. Additionally, NFP has demonstrated positive outcomes on community risk factors. The following outcomes have been observed among trial participants in at least one randomized, controlled trial of the NFP program: improved pregnancy outcomes (35% fewer cases of pregnancy-induced hypertension; 79% reduction in preterm delivery among women who smoke cigarettes), greater intervals between subsequent pregnancies (including a 28-month greater interval between the pregnancies of the first and second child among low-income, unmarried group); improved child health and development (including a 48% reduction in state-verified reports of child abuse and neglect by child age 15); increased school readiness (including a 50% reduction in language delays at child age 21 months), decreased involvement with the criminal justice system (including 59% reduction in child arrests at age 15), and increased self-sufficiency (83% increase in labor force participation by the mother by the child's fourth birthday). (8)

Current implementation of NFP in Robeson County has support from referral sources in the county and surrounding region as previously mentioned. The proposed expansion also has the support of several new referral sources located in Columbus County. The NFP program fits with current initiatives, priorities, organizational structures and supports as well as the community value system. This project has a broad base of support in Robeson and Columbus counties and includes a true community-wide effort to address healthier pregnancies and babies by bringing together a close collaboration among the school system and the health department while at the same time engaging key community partners to provide support and services that are beyond the scope of this project.

Readiness to Implement: Robeson County Health Department's capacity to implement the program as intended is evidenced by current success with the NFP model for over two years. Current program enrollment data indicate that the program is at capacity with 100 clients currently enrolled and steadily growing referrals. Program participants have high breastfeeding rates (63%), experience a 71% reduction in physical abuse/ domestic violence, and have high school enrollment (50%).

Northeast Collaborative (Edgecombe, Halifax, Hertford, and Northampton) : The four counties represented in Northeast NFP Collaborative are rural, economically depressed, and lack resources available in other regions of the state and across the country. In response to these needs, Action for Children North Carolina, began a multi-county collaborative in 2009. A community needs assessment conducted by this collaborative began consideration of NFP.

Model Selection: NFP was selected as the intensive home visiting program model for Edgecombe, Halifax, Hertford, and Northampton Counties based on the following:
As noted in the work by Dr. David Rubin of the Children's Hospital of Philadelphia, NFP implementation is effective in the rural settings. (9) NFP has been found effective for target populations (low income African-American, Caucasian, and Hispanic women/teens).
NFP has demonstrated positive outcomes on community risk factors. The following outcomes have been observed among trial participants in at least one randomized, controlled trial of the NFP program: improved pregnancy outcomes (35% fewer cases of pregnancy-induced

hypertension; 79% reduction in preterm delivery among women who smoke cigarettes), greater intervals between subsequent pregnancies (including a 28-month greater interval between the pregnancies of the first and second child among low-income, unmarried group); improved child health and development (including a 48% reduction in state-verified reports of child abuse and neglect by child age 15); increased school readiness (including a 50% reduction in language delays at child age 21 months), decreased involvement with the criminal justice system (including 59% reduction in child arrests at age 15), and increased self-sufficiency (83% increase in labor force participation by the mother by the child's fourth birthday). (10)

Readiness to Implement: Since January 2010, various constituents, policy makers and heads of human service agencies have continued to meet and collectively plan to ready the community for implementation of NFP. The Northampton County Health Department was selected as the implementing agency. The Northeast NFP Collaborative was provided provisional approval to implement pending dedicated funding on May 26, 2011 by the NSO. A readiness assessment onsite visit completed by DPH and NIRN on May 25, 2011 revealed a well prepared implementing agency and community collaboration on this project. While these communities have little prior experience in the implementation of an evidence-based model, they do have experience with engagement of the target population through a variety of health and family support programs. It is understood that this site will need additional supports in implementation which will be addressed through the NSO as well as through support from DPH and NIRN.

Gaston County – 38 Census Tracks: Gaston County is in the Southern Piedmont of North Carolina. Gaston County consistently exceeds the State averages in infant mortality, teen pregnancies, late entry to or no prenatal care, Medicaid births, mothers who smoke during pregnancy, and births to single mothers. NFP will be implemented in the portion of Gaston County with the highest incidence of risk factors that contribute to poor birth and child development outcomes.

Model Selection: In selecting NFP, Gaston intends to help first-time, low income mothers have healthy births, return to school, achieve financial self-sufficiency through meaningful employment, and raise healthy, capable, secure, and academically capable children. Specifically, NFP was selected because it has been found effective for target populations (low income African-American, Caucasian, and Hispanic women/teens). Additionally, NFP has demonstrated positive outcomes on community risk factors. The following outcomes have been observed among trial participants in at least one randomized, controlled trial of the NFP program: improved pregnancy outcomes (35% fewer cases of pregnancy-induced hypertension; 79% reduction in preterm delivery among women who smoke cigarettes), greater intervals between subsequent pregnancies (including a 28-month greater interval between the pregnancies of the first and second child among low-income, unmarried group); improved child health and development (including a 48% reduction in state-verified reports of child abuse and neglect by child age 15); increased school readiness (including a 50% reduction in language delays at child age 21 months), decreased involvement with the criminal justice system (including 59% reduction in child arrests at age 15), and increased self-sufficiency (83% increase in labor force participation by the mother by the child's fourth birthday). (11)

Readiness to Implement: The Gaston County Department of Health (GCDH) is the implementing agency and has completed nine months of planning with support from Prevent Child Abuse NC. In spring 2011, GCDH was provisionally approved pending funding by the NSO in April 2011 to implement the model. A readiness assessment onsite visit completed by DPH and NIRN on May 24, 2011 revealed a well prepared implementing agency and community collaboration for this project. The implementing agency has prior experience with the implementation of evidence-based programs. Implementation support will be provided through the National Service Office of NFP as well as through support from DPH and NIRN.

Buncombe County Zip Codes 28715, 28748, 28803 and 28806: Buncombe County is the only county in Western North Carolina considered urban. Far greater numbers of persons live in extreme poverty (at or below 50% of the federal poverty level) in Buncombe County than in Tier 1 counties. (12) The targeted zip codes have high rates of low birth weights, crime, school dropout, poor school performance (3rd grade testing), high Medicaid births, and teen pregnancies. While child maltreatment rates could not be broken down by zip code, 43% of substantiated cases were from the targeted sub-population geographic area.

***Model Selection*:** Buncombe County is expanding their current NFP program from four to five nurse home visitors. The Buncombe County Department (BCDH) of Health is the implementing agency and has implemented NFP since October 2009. Part of the North Carolina NFP Initiative, this community has taken a distinctive approach in their selection, adoption, and funding of NFP. Buncombe County first began exploring the possibility of implementing NFP in May 2007; in 2009, the county reclassified four existing nurse positions and half time data support from existing resources. BCDH sought funding from the Division of Public Health to fill the gaps in local funding. DPH and the three foundations that are currently funding other NFP sites across the State, through the Alliance, agreed to fund startup costs and provide funding for the NFP nurse supervisor position. Buncombe County received funding in July 2009 and implementation began in October 2009. BCDH achieved a full caseload of 100 first time low income moms within the first 9 months. Buncombe County provides 60% of the funding for their current NFP project through local funds (57%) and Medicaid revenues (3%). This is noteworthy as the other NC NFP sites receive 100% funding through the Alliance for implementation and may serve as an example for sustainability beyond the MIECHV grant funding period.

Readiness to Implement: Buncombe NFP is at capacity and has had to turn away 78 eligible clients this fiscal year. This demonstrates the need to expand NFP by one nurse home visitor to meet the needs of the targeted sub geographical area. BCDH has met all of the implementation guidelines set by NSO to assure model fidelity and have been approved to expand. A readiness assessment onsite visit completed by DPH and NIRN on May 23, 2011 revealed a well prepared implementing agency and community collaboration for this project. While these communities have little prior experience in the implementation of an evidence-based model, they do have experience with engagement of the target population through a variety of health and family support programs. Implementation support for this expansion will be provided through the National Service Office of NFP as well as through consultation and TA from DPH and NIRN.

Healthy Families America

***Fit with Selected At-Risk Communities*:** The HomVEE study found HFA to have 10 primary outcomes and 20 secondary outcomes favorable outcomes in: Child Health, Child Development and School Readiness, Reductions in Child Maltreatment, Positive Parenting Practices, Family Economic Self-Sufficiency, Linkages and Referrals. (13) HFA will be implemented in three at-risk communities: the Lesser Burke County community, and Mitchell and Yancey Counties The Lesser Burke County community was not included in North Carolina's State Plan for MIECHV FY 2010 funds; additional funds in FY 2011 now allow us to support this program.

Lesser Burke County : Located in western North Carolina, the Lesser Burke Geographic Catchment Area is defined as Burke County minus the identified pockets of affluence. Those affluent areas are defined as neighborhoods and subdivisions where the average home prices are greater than $150,000.00. County-level data indicates significant need for improvement in maternal and child health. Burke County has high rates of infant mortality, domestic violence, and poverty. The county has the 10th highest unemployment rate in North Carolina (14.52%). More than 21% of children were living below the poverty level in Burke in 2009. Local school officials reported 60% of the children enrolled in 2010 qualified for income-based free/reduced-price lunch. In 2009, 64.05% of the total 970 births were Medicaid eligible which is higher than the NC state rate of 51.7% and higher than comparable peer counties' average of 59.8%. Rates of prenatal care entry are low.

Model Selection: CVHF is an accredited site of HFA that has been successfully providing services to its target population in Burke County since June of 2000. The Catawba Valley Healthy Families program (CVHF) has an 11 year track record of success in a number of areas. A sample of CVHF outcomes demonstrates the effectiveness of the HFA model at addressing the needs of Burke's expectant mothers and new parents. These include: 1) The graduates of the CVHF program show significant change between pre- and post-test scores on a standardized measure of positive parenting attitudes (i.e., the Adult-Adolescent Parenting Inventory) which suggests a substantial shift away from attitudes and practices that have been associated with child maltreatment; 2) When compared to their age peers, children whose families graduated from CVHF exhibit higher levels of social and emotional competence as measured by the frequency with which they display social and behavioral challenges; 3) The rate of Rapid Repeat Births is significantly less for CVHF participants (18%) than for a comparison group (30%); 4) 100% of the families completing the CVHF program show a reduction in risk factors present at the time of enrollment; 5) In SFY '08-'09, 100% (99/99) of participating parents/couples reported regularly reading to their babies/children on average 5.46 days per week; and, 6) During SFY '08-'09, out of 60 individual parents who have graduated from the CVHF program and who represent 51 families, there were no substantiations of abuse/neglect as determined by data obtained by the Burke County Department of Social Services using the NC Child Protective Services Central Registry. (14)

A total of 228 families screened positive for CVHF services in SFY '09-'10. Due to limited capacity, CVHF enrolled only 16. Annually, CVHF receives, on average 100-130 referrals and, is only able to enroll 15-18 families per year.

Readiness to Implement: CVHF is an accredited site of HFA that has been successfully providing services to its target population in Burke County since June, 2000. A sample of

outcomes from that time to the present demonstrate the success CVHF has had in serving Burke's at-risk parents; they include: 96% of children assessed using a standardized developmental assessment tool have been in the "normal" range; 100% of participating families have been connected with a medical home; 100% of children have received scheduled well-visits; 100% of children received immunizations on schedule; only 2.7% of participating individuals in the high-risk families CVHF targets have had a substantiation of child maltreatment; and, since CVHF began tracking substantiations of child maltreatment of graduating participants in SFY '06-'07 there have been no substantiations of maltreatment for individuals in that group.

Toe River Health District (Mitchell and Yancey Counties) : Mitchell and Yancey Counties are two of the three counties which make up the Toe River Health District. These counties struggle with persistent poverty and related socio-economic problems, such as low literacy rates, high school drop-out rates, unemployment andunder-employment,

Model Selection: While these communities considered all four of the State's selected models, HFA and the NFP were found to have the best match with meeting community needs. While NFP met more of the desired outcomes of the community than HFA, it was concluded that HFA would be a "better fit" for these rural communities at this time. Examples of "goodness of fit" for HFA vs. NFP include: HFA allows local programs the flexibility to design services specifically to meet the unique needs of families and the rural community; Low number of first-time low income births would be prohibitive for implementation of an eight or four nurse NFP team; Clients may enter the program prenatally, but also up to the 3rd month of life of the target child and does not have to be a first time live birth to the targeted woman; and Research shows favorable outcomes in: child health, child development and school readiness, reductions in child maltreatment, positive parenting practices, family economic self-sufficiency, linkages and referrals.

***Readiness to Implement*:** The readiness assessment onsite visit to Mitchell and Yancey Counties on May 24, 2011 revealed a strong understanding of the model selected, commitment to the critical elements, and community collaboration on this project. Implementation of this project will be shared between the Toe River Health District and the Mitchell-Yancey Partnership for Children. While these communities have little prior experience in the implementation of an evidence-based model, they do have experience with engagement of the target population. This site will need additional supports in implementation which will be addressed through support from DPH and NIRN. Additionally, the project contracted with a NC based HFA National Peer Reviewer to provide model specific support.

Healthy Families AND Parents as Teachers- An Integrated Model

Fit with Selected At-Risk Communities: An integrated HFA and PAT program will be expanded in the City of Durham.

East Durham (1.2 square miles within the City limits of Durham) :The Healthy Families East Durham will operate in the East Durham Children's Initiative (EDCI) which consists of a 120-block contiguous area (1.2 square miles) east of downtown Durham. This community struggles with endemic poverty and associated poor health outcomes.

Model Selection: This project will expand an integrated HFA/PAT model into the EDCI neighborhood and will add three additional Family Support Workers to saturate this highest risk area. For the past two years, an early childhood workgroup has been planning the early childhood initiative for the EDCI neighborhood. The suggested service plan pinpointed intensive home visiting as one of the primary recommended intervention strategies in the EDCI neighborhood. While other models were considered, the community as a whole concluded that expanding their current Healthy Families Durham program would be most beneficial for a number of reasons. First, Healthy Families is a well-established and respected program in the community and has been operating in Durham for 15 years. Second, the needs of the EDCI require an expanded target population to include all pregnant women. The HFA model allows flexibility with the target population to include more than first time mothers. Additionally, HFA lies programs must provide culturally competent services in order to meet the credentialing requirements. Healthy Families East Durham expansion will serve both English-speaking and Spanish-speaking families, further increasing the diversity of the client base.

The integrated HFA/PAT model is an ideal fit for the East Durham community. HFA is designed to deal with the risk factors of family violence, poverty, risk of child abuse, stress, teenage pregnancy, and self-sufficiency. PAT, conversely, is designed to enhance knowledge of child development, improve parent/child interaction, and increase school readiness. Neither model is enough to meet the needs of the high-risk families in the EDCI neighborhood. However, the HFA structure of implementation combined with the psycho-education of the PAT curriculum creates a program that deals with both the psychosocial risk factors found in this community and the need to focus on child development and school readiness.

Readiness to Implement: *Healthy Families East Durham* is an expansion of an existing home visiting program in Durham. *Healthy Families Durham* is a credentialed HFA program. All Family Support Workers are also trained and certified to provide the PAT curriculum, *Born to Learn*. The Healthy Families model, as currently implemented in Durham, differs from the national model in several ways: (1) the Family Support Workers are professionals versus paraprofessionals; (2) there is a specific curriculum used in the home visiting intervention (PAT); (3) there are intervention modules established for families with domestic violence, substance abuse, and maternal depression; and (4) the Durham program is integrated into the Center for Child and Family Health (CCFH), which provides auxiliary services such as trauma treatment and psychiatric care for parents and children, when the need is indicated. In addition to 15 years of successful implementation of this model, CCFH has extensive experience in the implementation of evidence-based programs with model fidelity.

North Carolina's Experience with Implementing Selected Models

North Carolina has a long history of leveraging public and private partnerships to support evidence-based home visiting programs across our state. Since 2005, home visiting programs have been prioritized for funding and support by the state and private foundations. Leadership in this effort is currently provided by the Governor's Early Childhood Advisory Council (ECAC) and the Alliance for Evidence-Based Family Strengthening Programs (Alliance). Established in 2010 by the Governor's Office, the ECAC seeks to facilitate the development of a comprehensive early childhood system, of which home visiting is a crucial component. The

ECAC works collaboratively with the Alliance, a collaborative effort of state-level agencies and private foundations that fund family support and child maltreatment prevention programs in NC that has been meeting since 2006. The Alliance provides guidance and leadership for the successful implementation of evidence-based home visiting programs in the state.

In September 2010, the NC-MIECHV State Needs Assessment catalogued the scope of home visiting services in the state supported by public and private funds, including: 25 Early Head Start (EHS) programs (43.53% of infants and toddlers are enrolled in the home-based option), six Healthy Families America (HFA) programs, eight Nurse-Family Partnership (NFP) programs, and 85 Parents As Teachers (PAT) programs. Despite this large number of initiatives, however, these programs met only a small percentage of need in their communities; the estimated penetration rate for home visitation services in NC is approximately 3%.

North Carolina's Plan for Ensuring Implementation of Selected Models with Fidelity and Anticipated Challenges

Implementing and sustaining evidence-based programs within an early childhood system requires implementation capacity. The WCHS has contracted with the National Implementation Research Network (NIRN) to support North Carolina's efforts to develop the infrastructure needed within the state to support this outcome.

State infrastructure to support the funded programs for ensuring adherence to key or critical elements to ensure fidelity to each model through support to the sites at both the home visitor and administrative levels is part of this implementation capacity. While Prevent Child Abuse America (the purveyor for HFA) and PAT recommends state level support, it does not require it for states with multiple sites. However, NFP-NSO does require states with multiple implementing sites to begin to build the necessary state-level administration to support funded sites. The DPH and Alliance partners have begun this work in partnership with the NFP National Service Office. Developing a solid state infrastructure would require five functions to be shared between DPH and Alliance partners as follows:

1. *Nursing Practice Support for NFP home-visiting nurses and nurse supervisors*: DPH will provide this function through hiring a NFP State Nurse Consultant via this grant;
2. *Program Implementation Support*: The private foundations will contract with a non-profit agency; university or other non-governmental agency to provide the primary lead for this function with coordination with DPH.
3. *Generating and Using Data to Inform Performance Improvement*: DPH will provide this function via the Data Manager position and the NFP State Nurse Consultant;
4. *Advocacy and Political Support*: The private foundations will contract with a non-profit agency; university or other non-governmental agency to provide the primary lead for this function; and
5. *Fiscal Oversight, Budget Management, and Contracts Administration*: DPH will provide this function via the Home Visitation Program Director and Business Services Coordinator.

The NSO will ensure that NC provides the above reference drivers for quality implementation. We will receive consultation and TA from the NSO to help us build a quality infrastructure to support NFP. The NSO will help us address and resolve these challenges through training and technical assistance

HFA or PAT does not require state-level infrastructure, however, our stakeholders have requested that this be built into programming for home visiting. The two HFA sites and one integrated HFA-PAT site will receive the following supports to ensure adherence to model fidelity:

1. DPH has contracted with the National Implementation Research Network (NIRN) to support all program models.
2. Work will be done with these programs to ensure core program elements are implemented.
3. Through this grant we will ensure appropriate fiscal resources needed to ensure quality implementation. We have identified areas in need of change in the proposed budgets and will modify them as indicated to support quality implementation, such as increased funding for data support and training.
4. Another challenge to delivering a program with fidelity includes human resources and staff selection. Through this grant we will assist with identifying the appropriate human resources needed and with staff selection.
5. Support through NIRN to ensure "core drivers" for successful implementation.
6. Pre-service and in-service trainings will be supported and required as prescribed.
7. Ongoing consultation and coaching and program evaluation technical assistance. For HFA and PAT, these elements are not yet developed at a state level.

Challenges for the HFA and HFA-PAT site include the lack of a formalized consultation/TA and evaluation system with technical assistance. It will be critical that the National Offices actively support these models. An additional challenge will be program evaluation technical assistance. Evaluation drives the quality of implementation. Evaluations of model fidelity, consumer and staff satisfaction, and child/family outcomes are critical components of an agency evaluation system when delivering evidence-based programs. We will need to contract with the National Offices to obtain proficiency in this area. The final area of need is in technical assistance for quality assurance. Agencies implementing HFA and PAT will benefit from using program evaluation information to improve the quality of program delivery and outcomes for children and families. Agencies can enhance services through the establishment of feedback loops in which data are used by staff members and agency leadership to ensure high-quality programs. Again, we will need to contract with the national service organizations to obtain proficiency in this area.

SECTION 4: IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

Process for engaging at-risk community(ies) around the proposed State Home Visiting Plan
A collaborative process for engaging the at-risk communities was implemented prior to the release of NC's RFA for MIECHV FY 2010 funds. The first step in the process was to engage Division of Public Health's key partners in this initiative. A large and representative group was convened as the Steering Committee. Consensus was reached on the process to move forward with the Request for Applications. Data were collected and analyzed by State staff to identify communities at highest risk. A notice to alert communities to the home visiting funding opportunity, along with the SIR, was distributed broadly to local communities on March 31, 2011. Simultaneously, a contract was being processed at the State level to engage the National Implementation Research Network to support development of implementation teams at the State and local levels. The National Offices for the four evidence based programs supported for implementation in NC were contacted and information obtained from these expert sources was made available to potential applicants. A bidder's conference was held via webinar on April 13, 2011 and the Q and A document was distributed on April 20, 2011. The webinar was archived for continued viewing. State staff received and responded to numerous calls for technical assistance, data interpretation, clarification of issues, and discussion of models and interpretation of fidelity from across the State. The Request for Applications was distributed on April 6, 2011 and applications were due May 13, 2011.

State's approach to development of policy and to setting standards for NC-MIECHV
The State's initial step to assure strong support in policy and standard development was to assure that the Governor's Office, DHHS Office of the Secretary, Division of Public Health leadership and key partners had information on the importance of evidence based services, model fidelity, early childhood systems development accompanied by supporting data on proven outcomes. This effort began many years ago and laid the groundwork for strong interest in the home visiting program. The Governor's Senior Policy Advisor for Early Childhood who is facilitating development of the Governor's Early Childhood Advisory Council (ECAC) was successfully approached about using the Council as an advisory group to the NC Home Visiting Program. This arrangement will assure current knowledge of evidence based home visiting is available to all ECAC council members, that this effort will be included in early childhood system discussions, and that political and Early Childhood leaders will remain involved in the program's development and implementation.

Because the State is experienced with evidence based early childhood programs, there is a strong appreciation for the importance of model fidelity and is committed to endorsing the National Models guidance on appropriate implementation. Each community grantee chosen to participate in the NC MIECHV also agreed to meet the minimum policy and standards required by the model they chose, e.g. NFP or HFA. NC MIECHV sites will receive technical assistance, consultation, program guidance and monitoring on a regular basis to help assure successful outcomes.

Plan for working with the national model developer(s)

A. Nurse-Family Partnership Model

NC MIECHV will closely partner with the NFP National service Office to support NFP programs. NFP requires a contract between each local implementing agency and the national office that specifies a commitment to implement the program with fidelity to the model and specifies the commitments of both the local agency and the National Service Office to supporting program implementation. Renewal of the contract can and generally does involve a review of program performance with the option to renew based on the commitment of the agency to pursue and achieve good outcomes. (15)

B. Healthy Families America Model

The HFA national office staff will provide training and technical assistance to help communities implement the HFA model for all direct service staff and supervisors/program managers. Quality Assurance staff at the national level are available to provide technical assistance to programs as they complete the accreditation process. Sites will pursue HFA accreditation either as a four-year individual site accreditation or a four-year multi-site accreditation. To defray costs associated with the provision of technical assistance to HFA sites, affiliated sites will pay an annual affiliation fee. Additionally, HFA program sites are responsible for the costs associated with the HFA Peer Review Team to perform an on-site review.

A timeline for obtaining the curriculum or other materials needed

We anticipate a quick timeframe for obtaining curricula and materials for both the NFP and HFA programs given North Carolina's current relationships with NFP and HFA National Offices. We will link new sites to existing sites for mentoring and assistance in obtaining materials.

Description of initial and ongoing training and professional development activities

Local sites will obtain training from the model developers to ensure competency. Additionally, the State will provide local sites with assistance in: Workforce development; Staff recruitment and retention; Additional preparation for entry into NFP nurse home visitor positions; Basic orientation to public health, community health, home-based nursing practice, and/or maternal child health nursing; Training in evidence based models, systems work, implementation science, evaluation methodologies and analysis, motivational interviewing; Early childhood systems development; Data entry and analysis/review; Quality assurance/ continuous quality improvement; Program assessment techniques; Support of model fidelity; and other training identified to meet local needs.

Plan for recruiting, hiring, and retaining appropriate staff for all positions;

State Home Visiting Program:

The North Carolina Division of Public Health uses the Merit-Based Recruitment and Selection Plan to fill positions subject to the State Personnel Act (GS-126). Consideration is given to applicants who possess an equivalent combination of related training and work experience commensurate with the minimum job requirements. Only applicants who meet the minimum training and experience requirements will be referred for consideration. The DHHS will provide equal employment opportunity to all applicants without regard to race, religion, color, creed, national origin, sex, age, disability, or political affiliation/influence. All selection decisions are based solely on job-related criteria and comply with all federal and state employment laws, regulations and policies, and will be consistently applied to promote fairness, diversity and integrity. It is the commitment of the department to recruit qualified applicants and to promote

the recruitment of minorities, women, individuals with disabilities, and others who may be under-represented demographically through the use of sound HR practices and principles. Preferential treatment will not be given to any private organization or individual based on political affiliation or influence.

The State has hired the Program Director, Laura Louison, who has an MSW and MSPH and began June 9, 2011. Initial interviews for the nursing position were held and the position was reposted. A second round of interviews with new and promising applicants is being scheduled. Similarly the first round of interviews has been held for the Business Services Coordinator position. We are considering reposting for that position as well. A data manager position is being established. DPH Personnel has approved the position level and it has been forwarded to Office of State Personnel for final approval. We project that all of these positions will be filled by August or September. The positions will have strong program and supervisory support within the Children and Youth Branch as well as strong program support from the Section, Division, Department and Governor's level.

Local Community Programs' Plans for Recruiting, Hiring, and Retaining Staff:

Buncombe County Health Department

Buncombe NFP has not lost any staff since implementation began. The new nurse will be hired based on strong home visiting, prenatal and pediatric skills. There are strong internal candidates with Community Health Nursing experience. Buncombe NFP offers competitive compensation, top-rate health insurance and high quality weekly supervision.

Burke County Catawba Valley Happy Families

In accordance with HFA standards, CVHF seeks staff from diverse backgrounds that have experience serving culturally and ethnically diverse clients. In addition, careful attention is given to personal qualities that enable FSW/FAWs to build trusting, respectful relationships and address difficult topics with clients. Program management is provided by the CVHF Program Director who provides direct primary coaching/supervision to the Program Supervisor. The Program Supervisor provides direct coaching/supervision to the FSW/FAWs.

Gaston County Health Department

GCHD will hire, orient, and train the NFP Supervisor, who will then take lead responsibility to recruit four Nurse Home Visitors. All nurses must meet NFP standards; priority will be given to nurses who have strong cultural and linguistic competencies. The NFP Supervisor will help Nurse Home Visitors enhance their skills and accelerate their personal and professional development. When individuals or the team need guidance beyond what the NFP Supervisor can provide, we will request the assistance of an NFP consultant.

Healthy Families East Durham Plan for Recruiting, Hiring and Retention

Healthy Families Durham exceeds the hiring requirements of both the PAT model and the HFAn model. All home visitors for *Healthy Families Durham* must have at least a bachelor's degree, with a master's degree preferred. There are written procedures for interviewing and hiring, overseen by the Human Resource Manager of CCFH; active recruitment of bilingual home visitors is part of the hiring plan. Staff retention is a strength of *Healthy Families Durham*, as all current home visitors have been with the program at least three years. Staff retention is

enhanced by adequate salaries, weekly staff meetings, weekly reflective supervision, on-call supervisors, staff retreats, and ongoing training. To meet staffing patterns required by the national office of HFA, each Family Support Worker will initially serve 13 families (increasing to the standard caseload 15 by the end of year one), and one half-time supervisor will supervise 3 home visitors. This meets HFA requirements and far exceeds the staffing requirements of PAT. The Healthy Families framework requires reflective supervision, with full-time supervisors providing for no more than six home visitors. All 3 home visitors with the new *Healthy Families East Durham* will receive weekly supervision and have 24/7 on-call supervisor availability.

Northampton's Plan for Recruitment, Hiring and Retention
A community collaborative approach will be used to fill open NFP nurse positions. All four Health Departments involved will invest resources in recruiting Bachelors and Masters level nurses. The plan will be to announce the jobs in stages, in order to be cost-effective. To ensure the cultural and language competency of staff, specific recruitment strategies will be developed and targeted to the minority institutions of higher learning. The salary range for nurses employed by the Health Department is the highest in the community and makes these positions more competitive. The NFP guidelines for clinical supervision will be followed.

Robeson County Health Department's Plan for Recruitment, Hiring and Retention
As part of our ongoing recruitment strategy, RCHD serves as a clinical site for several colleges and universities. During recent student nurse rotations, several impressive candidates emerged. A moderate number of applications are also on file. Additionally, the position will be advertised in-house, as well as through the local Employment Security Commission. Currently, the NFP model utilizes weekly reflective practice and supervisor site visits every four months for each nurse home visitor to ensure high quality clinical practices.

Toe River's Plan for Recruitment, Hiring and Retention
The Toe River Health District will contract with the Mitchell-Yancey Partnership for Children for the Program Manager role, offering supervision and mentoring to support the home visitors' efforts to meet HFA goals and objectives and for quality and quantity of work. The program coordinator will serve as the leadership team's key staff in implementation of the HFA program. FSW limited case loads of approximately 15 families will ensure parents will receive the time and attention needed to be successful. A high level of quality supervision will be provided through collaboration between the program manager and the local health department supervisors. Local health department supervisors will provide daily supervision for HFA home visitors.

Subcontractor(s)
Subcontractors are not currently a part of the NC plan. If a change is made to the current plan, subcontractors will be held to the same requirements as contractors.

Plan to ensure high quality clinical supervision and reflective practice
NC's plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors will begin with a capacity-building framework. NC proposes to fund the following staff positions to support the initiative: Home Visitation Program Director, State NFP Nurse Consultant, Program Assistant, and Data Manager.

The ***Program Director,*** Laura Louison, MSW, MSPH, is responsible for new site development and community planning to ensure that all local community grantees have the knowledge, skills, tools, and support needed to sustain the program, adhere to model fidelity and build strong teams. The Director is responsible for fiscal and program oversight, evaluation monitoring, budget management and contracts administration.

The ***NFP State Nurse Consultant*** is responsible for clinical oversight to local NFP sites and policy and workforce development. This position ensures that all nurse-home visitors and their supervisors are prepared and supported in delivering NFP, with fidelity to the model, to diverse communities and families and helps local teams interpret client data for quality improvement. A master's degree in nursing or related area and five years of experience in public health nursing, including one year in a supervisory capacity is required for this position. Experience as a NFP Nurse Home Visitor or Supervisor is strongly preferred.

The range of duties for the ***Business Services Coordinator*** includes administrative and program support, budget management, program marketing, customer service, event planning, report writing, summarizing/reconciling information or financial data, record management, data review, and contract service monitoring and training for local staff. This position will be supervised by the Program director.

The ***Home Visiting Data Manager*** is responsible for performing collecting and complex statistical analyses of data from a wide variety of sources including but not limited to the State and National Home Visiting Benchmarks/Constructs, BRFSS, the National Early Childhood Home Visiting Survey, and CMIS data. This data will address all age groups, racial/ethnic groups, socioeconomic groups, geographic areas, and key environments in which families receiving MIECHHV services are provided. The position will be supervised by the NC MIECHV Program Director and work closely with the Best Practices Data Manager and staff in the Best Practices Unit, and will participate in the development and implementation of the NC Home Visiting State Plan for the improvement of maternal, infant and early childhood home visiting services.

State staff will work closely with the local implementing communities, the National Offices for NFP and HFA, the ECAC, and Alliance members to ensure high quality supervision for the models. Each community grantee will assure through a contractual arrangement, monitoring, support, technical assistance and data analysis that programs are providing appropriate and constructive supervision and reflective supervision. If appropriate training in reflective supervision will be arranged for local sites. The Home Visiting Program Director and Nurse Consultant will ensure that clinical supervision standards are reviewed regularly with grantees.

The estimated number of families served:

Geographic Area	**Model**	**Number Families To Be Served**
Buncombe County zip codes 28715, 28748, 28801, 28803, and 28806	NFP	25 families per cohort/one nurse
Lesser **Burke** County (excluding pockets of affluence in identified neighborhoods)	HFA	24 families first year
Northeast Central **Durham** zone (a 120 block area) in Durham County	HFA/PAT curriculum	45 families per cohort

Gaston County (38 census tracts)	NFP	100 families per cohort/ four nurses
Northampton, Hertford, Halifax and Edgecombe Counties	NFP	100 families per cohort/ four nurses
Robeson and Columbus Counties	NFP	100 families per cohort
Yancey and Mitchell Counties	HFA	26 families first year

The programs are projected to serve a total of 420 families in the first year.

A plan for identifying and recruiting participants;

Each community grantee has agreed to identify and recruit participants based on the chosen model's criteria. Priority will be given to low-income eligible families and families in high risk communities as indicated in the statewide needs assessment. Even though not all sites indicated plans for a triage system, this possibility will be examined with each site for feasibility. Programs will rely largely on referrals from other programs and family referrals. The Pregnancy Medical Home program and the Pregnancy Care Management program are excellent sources for referrals of first time mothers prenatally. The county sites also plan to utilize referrals and outreach resources specific to their county to ensure families are aware of the services available through the home visiting models.

A plan for minimizing the attrition rates for participants enrolled in the program;

NC's plan for minimizing the attrition rates for participants enrolled in the community HV programs emphasizes the provision of on-going support and structure needed by the community grantees and their staff. Recent research suggests that the biggest challenge to HV programs is attrition of clients and staff turnover has been identified as having a major impact on clients leaving the program. All community grantees are required to develop staff retention plans with support from the State Program Director, as well as incentives for client participation.

An estimated timeline to reach maximum caseload in each location.

The sites have estimated the following timelines:

- Buncombe: Approximately 6-9 months for a full caseload of 25 clients.
- Burke: Approximately 5-6 months to enroll 24 families.
- Durham: Enrollment of 39 clients by month 4; 45 clients by end of year.
- Gaston: Approximately 100 participants in nine months.
- Northampton: Approximately 100 participants in nine months.
- Robeson: Approximately 100 participants in nine months
- Toe River: Approximately 6-9 months to enroll 26 families

Operational plan for the coordination between the proposed home visiting program(s) and other existing programs and resources in those communities

The National Implementation Research Network (NIRN) will work with key state-level and local level stakeholders to build implementation capacity through their contractual agreement with the Division of Public Health. NIRN will provide support to key Family Strengthening stakeholders and counties as they begin rolling out the Home Visitation Initiative in North Carolina. NIRN will work with the Home Visitation Sites to develop their capacity to fully and effectively implement their evidence-based models so that the intended outcomes for children and their families are achieved. Local sites have developed the following plans for coordination:

Buncombe County
Buncombe County's NFP expansion is supported by considerable community resources and partners in the county. These resources include: the Interagency Management Team, a local consortium of agency health, mental health, juvenile justice, education and human services leaders that provides oversight of targeted case management and care coordination; Buncombe County Children's Collaborative, who promote public awareness, advocacy, and collaboration of agencies, families, and the community; Children First, an organization providing advocacy for children's issues locally; and the BCDH Leadership Action Planning Process, a systems approach to planning for handling key health priorities of BCDH.. Additional support is available from CC4C and Pregnancy case Management, who will be referral partners for NFP.

Burke County
CVHF has cultivated a large network of public and private collaborative partners to coordinate access to community resources, including health, mental health, early childhood, substance abuse, and domestic violence agencies.

Durham County
The EDCI and the *Healthy Families East Durham* expansion has broad-based community support. Existing resources include, but are not limited to, the involvement from more than 30 Durham-based nonprofit organizations, Durham Public Schools, local businesses, local philanthropy and Duke University Health System. EDCI has the unanimous support of all of Durham's local elected officials including: the Durham Public School Board, the Durham County Board of Commissioners, and the Durham City Council. Leaders of *Durham Connects*, the newborn nursing program that will be the primary referring agency, have already agreed that the *Durham Connects* Advisory Board will merge with the Home Visiting Advisory Board. The Program Director for the *Healthy Families East Durham* expansion, Jan Williams, LCSW, will participate in the Local Interagency Coordinating Council (LICC) in order to facilitate blending this program into the continuum of early childhood services. The LICC meets monthly to coordinate, plan, and expand the system of care in Durham for young children; and all agencies are represented that serve children 0-3 years

Gaston County
GCHD's work to improve birth outcomes in Gaston County includes initiatives to achieve successful pregnancies, prevent teen pregnancies, and help new mothers raise healthy infants. GCHD places great emphasis on issues of maternal and child health. Through GCHD's pregnancy prevention and infant mortality reduction programs, it has built a trusting relationship with the Boys and Girls Club of Gaston County, the Gaston Family YMCA, the Alliance for Children and Youth, and our county's most influential institution: the faith community. GCHD also has a growing relationship with organizations serving the Latino community. GCHD's long-standing relationship with the Gaston County Schools focuses primarily on immunizing students, resolving disease outbreaks, and taking referrals of sexually-active and pregnant teens from school social workers and nurses. The latter is critically important, as it reflects cooperation by a school system that does not teach comprehensive sex education.

Northampton

Each of the four counties has several components necessary to develop a coordinated early childhood system. The Local Partnership for Children in each county is responsible for developing a comprehensive community-based early childhood system with a goal of strengthening families and ensuring that young children are healthy and ready to succeed when they enter kindergarten. Also, each Health Department has developed its own system to coordinate care for pregnant mothers and young children to ensure access to the appropriate services and supports. Once funding is confirmed, a Community Advisory Board, a model element of the NFP program, will be established that will act as the governance body for the proposed initiative.

Robeson County
The NFP program collaborates and coordinates with the Department of Social Services, all of the OB/GYNs in the county as well as in surrounding counties, the regional hospital, Community Innovations for mental health issues, the Children's Developmental Service Center for the region, the public school system, their school nurses and social workers, and other key leaders previously mentioned in our area. These collaborations will carry over to the expanded operation and have been discussed with Columbus County leaders; Columbus County partners have been identified in regards to these issues and resources.

Toe River
Toe River's HFA program will be supported by multiple community agencies who will share resources and referrals to support the new program. As the grant applicant, employer and program manager Toe River Health District will be ultimately responsible for the success of the program. TRHD will enter into contracts with other partners that have different areas of expertise and will be responsible for assuring that the terms of the contracts are met, terminating contracts if necessary and locating new resources to ensure desired outcomes. Program supervision that assures model fidelity and quality assurance activities will be contracted to the MYPFC. HFA staff will be employed by the Toe River Health District and located in the Mitchell and Yancey County Health Departments. Graham Children's Health Services will provide staffing for the leadership team and independent evaluation services. Additionally, GCHS will assist the Mitchell and Yancey HFA program with evaluation. Many of the children served by the HFA program will be involved with the local department of social services. Membership in the leadership team will allow social services staff to have input on the direction of the program, to provide both informal and formal feedback to other leaders. The leadership team will keep these key players in the lives of at risk children informed and invested in the program and help ensure that appropriate program referrals occur.

A plan for obtaining or modifying data systems for ongoing continuous quality improvement
North Carolina will contract with Efforts to Outcomes (ETO), which is part of the software company Social Solutions, for a data management system. ETO has been implemented by the NFP for their case management documentation, data collection and data analysis. ETO is also in the process of developing and implementing data collection for HFA. Ideally, North Carolina will begin data collection in ETO as soon as funded project activities begin (or continue data collection, for expansion sites). ETO is poised to go to scale quickly and efficiently within the state and provides an excellent, reliable web-based tool in which home visitors will document their cases.

State's approach to monitoring, assessing, and supporting implementation with fidelity
NC has contracted with the National Implementation Research Network to provide general and targeted capacity building (through training and intensive technical assistance) to increase the knowledge base of key state and county Family Strengthening stakeholders related to the science and practice of implementation, systems transformation, and scale-up of evidence-based practices. NIRN will guide the development of a leadership and implementation team at the state level that will provide leadership in the planning and development of a coordinated system of supports for the implementation of the evidence-based home visiting programs.

The local programs will be monitored pursuant to the State of N.C. contract monitoring policies. The Home Visiting Initiative staff will serve as contract administrators and be responsible for defining objectives, setting timelines, and monitoring the process and model fidelity throughout the terms of the contracts. The grantees will be monitored for compliance with performance requirements related to model fidelity and the achievement of expected outputs and outcomes. If problems are identified, corrective action plans with specific timelines and activities must be developed and monitored for implementation and compliance. Technical assistance and quality improvement support will be available to all local sites for fidelity and quality assurance. A data team at the State level will be monitoring for quality assurance on a monthly basis.

A discussion of anticipated challenges to maintaining quality and fidelity
Anticipated challenges to maintaining quality and model fidelity include budget challenges, staff turnover, training and orientation, attrition and related issues. With respect to budgets, contracts will be completed and in place with local sites by September 29, 2011. The Business Service Coordinator will track budget expenditures and make sure they are submitted regularly so that sites will be reimbursed quickly. NC is experiencing less staff turnover because of economic challenges, especially at the local levels where position openings are limited. The State will work with each site to assure that supports for staff are implemented and maintained. A complete orientation at the local and State level will be provided to staff at the home visiting sites. The resources and information available through NIRN is interesting and motivates staff to use their available tools. National level training will be supported and attended by State staff as well as local.

A list of collaborative public and private partners
NC-MIECHV will be guided by the Governor's Early Childhood Advisory Council (ECAC). The ECAC has agreed to be the advisory council for the NCHV Program. The Governor has called upon the North Carolina ECAC to lead the state in creating and sustaining a shared vision for young children and a comprehensive, integrated system of high quality early care and education, family strengthening, and health services that support ready children, families, and communities. The ECAC will ensure that NC-MIECHV appropriately coordinates with state-level stakeholders, including the Alliance. Because these group is comprised of most of the key stakeholders, coordination will be easily facilitated.

Assurance that NC MIECHV is designed to result in participant outcomes noted in the legislation

The State will support only evidence based programs that have been shown through research to produce the appropriate outcomes. The engaged key partners are planning at both the state and local levels and will be working with the selected models' national office(s) to solve data issues and other challenges that arise. The National Implementation Research Network is contracted to ensure implementation takes place appropriately and leads to the anticipated outputs and outcomes.

Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments

Each grantee will complete individual assessments as required in the program models, provide the appropriate services, and participate in continued quality improvement and evaluation activities. Model fidelity is included in the contract language and will be addressed through technical assistance as well as monitoring activities.

Assurance that services will be provided on a voluntary basis

All services will be provided pursuant to model requirements and clients' voluntary agreement. This requirement will be included in the legal contract language for all grantees.

Assurance that the state will comply with the Maintenance of Effort Requirement

The State of N.C. will not reduce existing funding currently being used with evidence-based models for the purpose of funding the Home Visiting Initiative. No supplantation will be allowed in contracts with local grantees.

Assurances that priority will be given to serve eligible participants

Priority will be given to eligible participants who:

- Have low incomes;
- Are pregnant women who have not attained age 21;
- Have a history of child abuse or neglect or have had interactions with the child welfare system;
- Have a history of substance abuse or need substance abuse treatment;
- Are users of tobacco products in the home;
- Have, or have children with, low student achievement;
- Have children with developmental delays or disabilities/
- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Evidence of this will be collected as part of the outcome data and benchmarks and requirements for these assurances will be in the contract language for each grantee. These areas will be reviewed through the monitoring and quality assurance processes at both the State and local levels.

SECTION 5: PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS

Overarching Data Collection System for Early Childhood in NC

North Carolina will contract with the software company Social Solutions to use Efforts to Outcomes (ETO) for data collection. ETO has been implemented by the NFP for their case management documentation, data collection and data analysis. ETO is also in the process of developing and implementing data collection for HFA. Ideally, North Carolina will begin data collection in ETO as soon as funded project activities begin (or continue data collection, for expansion sites). ETO is poised to go to scale quickly and efficiently within the state and provides an excellent, reliable web-based tool in which home visitors will document their cases. Training via webinars is already available, and additional training or technical assistance can be provided as-needed to ensure everyone working with the home visiting programs can use the data collection tools accurately. ETO is already in place with NFP sites, and can be integrated with the HFA sites.

Data collection on all benchmarks:

NFP and HFA programs provide excellent structure for data collection. By comparing the collected measures from each model, we have aimed to develop an overarching state structure for data collection without adding undue burden of additional data collection beyond what the evidence-based models require. Standard measures will be used for all constructs, since the implementation of these models in North Carolina will serve very similar populations. Measures are selected to be developmentally appropriate to the population served. Data will be collected on all eligible families enrolled in home visiting programs. Data will be collected for all constructs under each benchmark area, and will be made readily available to those carrying out the home visiting programs for decision-making and CQI activities Data collected under each benchmark will be coordinated and aligned with other relevant State and local data collection efforts by linking data across the continuum of health care, and also with partners in social services and education.

Individual demographic and service-utilization data on participants will be collected upon enrollment into the programs, using standard tools common to NFP and HFA. Gathering accurate data is the first and most important step in this process. We will collect it through client interviews (using standardized NFP and HFA questions), standardized measures (such as the Ages and Stages Questionnaire) and state level administrative data.

Proposed measures:

The below proposed measures were revised per HRSA consultation from those originally submitted in the NC MIECHV Updated State Plan. North Carolina proposes to show improvement in all benchmarks, as defined by the measures in the table below. Administrative data proposed to be used is primarily from the Department of Social Services, also under the Department of Health and Human Services in North Carolina. The following table also describes standardized tools we propose to use with their intended population, and documents the reliability/validity of the tools.

Benchmark 1: Improved Maternal and Newborn Health: Indicators

Constructs	Indicator	Operational Definition/Calculation	Definition of Improvement	Population	Data Source / Measurement Tool
Prenatal Care	Percent of women receiving recommended* number of prenatal visits by trimester.	Number of women receiving recommended number of prenatal visits by trimester/Number of pregnant women in program	Increases	Women	Interview and web-based management system
Parental use of alcohol, tobacco or illicit drugs.	Percent of women reduce their use of alcohol, tobacco or illicit drugs during pregnancy	Number of women who have reduced their use of alcohol, tobacco or illicit drugs from program enrollment to one year post-partum/Number of women in program using alcohol, tobacco or illicit drugs at program enrollment	Reduces	Women	Interview and web-based management system
Preconception care	Percent of women who receive preconception care between birth of 1st child and conception of 2nd child.	Number of women who receive at least one well woman visit between birth of 1st child and conception of 2nd child, not including postpartum 6-week visit/Number of women in program	Increases	Women	Interview and web-based management system
Inter-birth intervals	Average length of inter-birth interval for women who have a subsequent pregnancy while in the program	Length of time between first and second birth/Number of women with subsequent pregnancies while in the program	Increases	Women	Interview and web-based management system
Screening for maternal depressive symptoms.	Percent of women screened for depressive symptoms	Number of women screened at program intake/ Number of women in program	Increases	Women	Edinburgh Scale for NFP**; Brief Symptom Inventory 18 for HFA***
Breastfeeding	Percent of infants who receive breast milk for at least the first six months of life	Number of infants who receive breast milk for at least first six months of life/ Number of infants in the program	Increases	Children	Interview and web-based management system
Well-child visits	Percent of children receiving recommended**** well-child visits	Number of children receiving recommended well-child visits/Number of children in program	Increases	Children	Interview and web-based management system
Maternal & child health insurance status	Percent of child program participants with health insurance by three months from program enrollment	Number of child program participants with health insurance by three months from program enrollment/Number of child program participants	Increases	Women and Children	Interview and web-based management system

*Recommended prenatal care as specified by Guidelines for Perinatal Care, 6th Edition. (American College of Obstetricians and Gynecologists & American Academy of Pediatrics, 2007)

** The Edinburgh Depression Scale “gives clinically meaningful results as a psychological screening tool. It is sensitive to change both during the course of

pregnancy and after childbirth. A recent review of validation studies of the EPDS concluded that most studies reviewed showed high sensitivity for the EPDS, although uncertainty remained regarding the comparability between the sensitivity and specificity estimates of the different EPDS versions." Eberhard-Gran M, Eskild A, Tambs K, Opjordsmoen S, Samuelsen SO: **Review of validation studies of the Edinburgh Postnatal Depression Scale.** *Acta Psychiatr Scand* 2001, **104:**243-249. "Cox *et al* (1996) validated the scale for use with non-postnatal women and it has also been validated for use with the mothers and fathers of toddlers (Thorpe, 1993). The scale can be administered by computer with adequate acceptability and performance (Glaze & Cox, 1991)." http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf

*** The Brief Symptom Inventory 18 "gathers patient-reported data to help measure psychological distress and psychiatric disorders in medical and community populations." "The validity of the BSI-18 as a measure of general distress was further supported by its correlations with theoretically relevant constructs. The BSI-18's reliability was evidenced in its demonstration of high internal consistency." J Comm Psychol 33: 139–155, 2005.

****Recommended well child visits as specified in the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition.

. (American Academy of Pediatrics, 2008)

Benchmark 1: Improved Maternal and Newborn Health: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Prenatal Care	Percent of women receiving recommended number of prenatal visits by trimester.	Home visitor will ask mothers a standard question.	At each home visit	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Parental use of alcohol, tobacco or illicit drugs.	Percent of women using alcohol, tobacco or illicit drugs during pregnancy	Home visitor will ask mothers a standard question.	At each home visit	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Preconception care	Percent of women who receive preconception care between birth of 1st child and conception of 2nd child.	Home visitor will ask mothers a standard question.	At each home visit.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Inter-birth intervals	Percent of women who have a subsequent pregnancy while in the	Home visitor will ask mothers a standard question.	At each home visit.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program

	program			worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Screening for maternal depressive symptoms.	Percent of women screened for depressive symptoms	Home visitor will administer screening tool (Edinburgh Scale for NFP*; Brief Symptom Inventory 18 for HFA**)	According to program guidelines, at least at program entry and one year post-partum	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Breastfeeding	Length of time infant receives breast milk.	Home visitor will ask mothers a standard question.	At each home visit.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Well-child visits	Percent of children receiving recommended well-child visits	Home visitor will ask mothers a standard question.	At each home visit.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Maternal & child health insurance status	Percent of program participants, women and children, with health insurance	Home visitor will ask mothers a standard question.	Monthly.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment. All indicators would be collected and reported annually for the duration of the MIECHV grant.				

Benchmark 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits: Indicators

Constructs	Indicator	Operational Definition/Calculation	Definition of Improvement	Population	Data Source / Measurement Tool
Visits for children to the ED from all causes.	Percent of children with emergency department visits for any reason	Number of ED visits/ Number of children enrolled in the program	Decreases	Children	Interview and web-based management system

Visits of mothers to the ED from all causes.	Percent of mothers with emergency department visits for any reason	Number of ED visits/ Number of children enrolled in the program	Decreases	Mothers	Interview and web-based management system
Info or training on prevention of child injuries such as safe sleeping, shaken baby syndrome, or traumatic brain injury.	Percent of participants who received educational information on safety and prevention of child injuries	Number of participants receiving info or training on injury prevention/Number of families enrolled in the program.	Increases	Families	Interview and web-based management system
Incidence of child injuries requiring medical treatment.	Percent of children who have injuries and ingestions requiring medical treatment	Number of enrolled children who have injuries or ingestions requiring medical treatment either at an emergency department or doctor's office/Number of children enrolled in the program	Decreases	Children	Interview and web-based management system
Reported suspected maltreatment for children in the program**	Percent of children in the household with suspected maltreatment reported	Number of suspected cases of maltreatment of children in the household/ Number of children in the household	Decreases	Children	Administrative child welfare data
Reported substantiated maltreatment for children in the program**	Percent of children in the household with substantiated maltreatment reported	Number of substantiated cases of maltreatment of children in the household/ Number of children in the household	Decreases	Children	Administrative child welfare data
First-time victims of maltreatment for children in the program.**	Percent of children in the household who are first-time victims of maltreatment	Number of children in the household who are first-time victims of maltreatment/ Number of children in the household	Decreases	Children	Administrative child welfare data
** Data will be stratified by age category (0-12 months, 13-36 months and 37-84 months) and maltreatment type (neglect, physical abuse, sexual abuse, emotional maltreatment and other). Data use agreements will be established with the Department of Social Services to facilitate data sharing for this indicator.					

Benchmark 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Visits for children to the ED from all causes.	Percent of children with emergency department visits for any reason	Home visitor will ask mothers a standard question.	At each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.

Visits of mothers to the ED from all causes.	Percent of mothers with emergency department visits for any reason	Home visitor will ask mothers a standard question.	At each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Info or training on prevention of child injuries such as safe sleeping, shaken baby syndrome, or traumatic brain injury.	Percent of participants who received educational information on safety and prevention of child injuries	Home visitor will document in web-based management system when information or training is provided	Ongoing	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Incidence of child injuries requiring medical treatment.	Percent of children who have injuries requiring medical treatment	Home visitor will ask mothers a standard question.	At each home visit.	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Reported suspected maltreatment for children in the household**	Percent of children with suspected maltreatment reported	Administrative report obtained from DSS (information-sharing agreement)	Monthly	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Reported substantiated maltreatment for children in the household**	Percent of children with substantiated maltreatment reported	Administrative report obtained from DSS (information-sharing agreement)	Monthly	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
First-time victims of maltreatment for children in the household **	Percent of children who are first-time victims of maltreatment	Administrative report obtained from DSS (information-sharing agreement)	Monthly	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment.				

All indicators would be collected and reported annually for the duration of the MIECHV grant.

Benchmark 3: Improvements in School Readiness and Achievement: Indicators

Constructs	Indicator	Operational Definition/Calculation	Definition of Improvement	Population	Data Source / Measurement Tool
Parent support for children's learning and development	Percent of parents whose screening tool score for support for children's learning and development increases over one year in the program	Number of parents whose score on screening tool after one year increases/ Number of parents screened	Increases	Parents	Interview and home visitor observation, web-based management system
Parent knowledge of child development and of their child's developmental progress.	Percent of parents whose screening tool score for knowledge of child development and their child's developmental progress increases over one year in the program	Number of parents whose score on screening tool after one year increases/ Number of parents screened	Increases	Parents	Interview and home visitor observation, web-based management system
Parenting behaviors and parent-child relationships (e.g. discipline strategies, play interactions).	Percent of parents whose screening tool score for parenting skills improve over one year in the program	Number of parents whose score on screening tool after one year increases/ Number of parents screened	Increases	Parents	Interview and home visitor observation, web-based management system
Parent emotional well-being or parenting stress.	Percent of parents whose screening tool score for emotional well-being improves over one year in the program	Number of parents whose score on screening tool after one year increases/ Number of parents screened	Increases	Parents	Interview and home visitor observation, Edinburgh Screening Tool, web-based management system
Child's communication, language and emergent literacy.	Percent of children whose communication, language and emergent literacy improve over one year in the program	ASQ score at program enrollment/ASQ score after one year	Increases	Children	ASQ scores, home visitor observation, web-based management system
Child's general cognitive skills.	Percent of children whose general cognitive skills improve over one year in the program	ASQ score at program enrollment/ASQ score after one year	Increases	Children	ASQ scores, home visitor observation, web-based management system
Child's positive approaches to learning including attention.	Percent of children whose positive approaches to learning improve over one year in the program	ASQ score at program enrollment/ASQ score after one year	Increases	Children	ASQ scores, home visitor observation, web-based management system
Child's social behavior, emotion regulation and emotional well-being.	Percent of children whose social behavior, emotion regulation and emotional well-being improve over one year in the program	ASQ-SE score at program enrollment/ASQ score after one year	Increases	Children	ASQ-SE scores, home visitor observation, web-based management system

Child's physical health and development.	Percent of children whose growth and development are appropriate over one year in the program	Physical health and development score at program enrollment/Physical health and development score after one year	Increases	Children	Weight, height, BMI collected. Head circumference collected on infants. Home visitor assessment, web-based management system
The Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire: Social Emotional (ASQ-SE) and Edinburgh Depression Scale have psychometric validity and reliability. The questions asked of clients to gather other data have been tested formatively to assure clarity of interpretation by the client and nurse home visitor, and connection to the constructs being assessed. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems. "ASQ-3 has a new standardization with an unrivaled sample that closely mirrors the U.S. population in geography and ethnicity and includes children of all socioeconomic statuses. The sample includes 15,138 children whose parents completed 18,232 questionnaires. Reliability, validity, sensitivity, and specificity are all excellent: Reliability: Test-retest: .92, Inter-rater: .93, Validity.82 to .88, Sensitivity.86, Specificity, .85." http://agesandstages.com/what-is-asq/faq/ The Edinburgh Depression Scale "gives clinically meaningful results as a psychological screening tool. It is sensitive to change both during the course of pregnancy and after childbirth. A recent review of validation studies of the EPDS concluded that most studies reviewed showed high sensitivity for the EPDS, although uncertainty remained regarding the comparability between the sensitivity and specificity estimates of the different EPDS versions." Eberhard-Gran M, Eskild A, Tambs K, Opjordsmoen S, Samuelsen SO: **Review of validation studies of the Edinburgh Postnatal Depression Scale.** *Acta Psychiatr Scand* 2001, **104:**243-249. "Cox *et al* (1996) validated the scale for use with non-postnatal women and it has also been validated for use with the mothers and fathers of toddlers (Thorpe, 1993). The scale can be administered by computer with adequate acceptability and performance (Glaze and Cox, 1991)." http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf					

Benchmark 3: Improvements in School Readiness and Achievement: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Parent support for children's learning and development	Percent of parents whose support for children's learning and development increases over one year in the program	Home visitor will ask parents a standard question and observe their interactions with their child(ren).	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Parent knowledge of child development and of their child's developmental progress.	Percent of parents whose knowledge of child development and their child's developmental progress increases over one year in the	Home visitor will ask parents a standard question and observe their interactions with their child(ren).	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current

	program			indicator. State-level administrative reports will be reviewed on a regular basis.
Parenting behaviors and parent-child relationships (e.g. discipline strategies, play interactions).	Percent of parents whose parenting skills improve over one year in the program	Home visitor will ask parents a standard question and observe their interactions with their child(ren).	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Parent emotional well-being or parenting stress.	Percent of parents whose emotional well-being improves over one year in the program	Home visitor will administer screening tool.	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Child's communication, language and emergent literacy.	Percent of children whose communication, language and emergent literacy improve over one year in the program	Home visitor will administer screening tool and observe child.	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Child's general cognitive skills.	Percent of children whose general cognitive skills improve over one year in the program	Home visitor will administer screening tool and observe child.	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Child's positive approaches to learning including attention.	Percent of children whose positive approaches to learning improve over one year in the program	Home visitor will administer screening tool and observe child.	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Child's social behavior,	Percent of children whose	Home visitor will	Scores at program	Reports can be generated as-needed from web-based

emotion regulation and emotional well-being.	social behavior, emotion regulation and emotional well-being improve over one year in the program	administer screening tool and observe child.	enrollment and at one year; observations at each home visit	case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Child's physical health and development.	Percent of children whose growth and development are appropriate over one year in the program	Home visitor will assess and observe child.	Scores at program enrollment and at one year; observations at each home visit	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment. All indicators would be collected and reported annually for the duration of the MIECHV grant.				

Benchmark 4: Domestic Violence: Indicators

Constructs	**Indicator**	**Operational Definition/Calculation**	**Definition of Improvement**	**Population**	**Data Source / Measurement Tool**
Screening for domestic violence	Percent of women screened for domestic violence	Number of women screened for domestic violence /Number of women enrolled in program	Increases	Families	Interview and web-based management system
Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence shelters (e.g., shelters, food pantries)	Percent of women identified for the presence of domestic violence who receive referrals to relevant domestic violence shelters	Number of women identified for the presence of domestic violence who receive referrals to relevant domestic violence shelters / Number of women identified for the presence of domestic violence	Increases	Families	Interview and web-based management system
Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	Percent of women identified for the presence of domestic violence for whom a safety plan was completed	Number of women identified for the presence of domestic violence for whom a safety plan was completed / Number of women identified for the presence of domestic violence	Increases	Families	Interview and web-based management system

Benchmark 4: Domestic Violence: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Screening for domestic violence	Percent of women screened for domestic violence	Home visitor will screen mothers	At program enrollment, at one year in program, and periodically according to model guidelines	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence shelters (e.g., shelters, food pantries)	Percent of women identified for the presence of domestic violence who receive referrals to relevant domestic violence shelters	Home visitor will ask mothers a standard question.	At each home visit for families identified for the presence of domestic violence	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	Percent of women identified for the presence of domestic violence for whom a safety plan was completed	Home visitor will ask mothers a standard question and update safety plan	At each home visit for families identified for the presence of domestic violence	Reports can be generated as-needed from web-based case management system for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment. All indicators would be collected and reported annually for the duration of the MIECHV grant.				

Benchmark 5: Family Economic Self-Sufficiency: Indicators

Constructs	**Indicator**	**Operational Definition/Calculation**	**Definition of Improvement**	**Population**	**Data Source / Measurement Tool**
Household income and benefits	Total dollar value of all household income and benefits	Total household income/Total number of households in the program	Increases	Families	Interview and web-based management system
Employment of adult members of the household	Total number of hours worked	Number of paid hours worked / Total number of adults in the household	Increases	Families	Interview and web-based management system
Health insurance status	Health insurance status of all household members	Number of household members with health insurance/Total number of household members in the program	Increases	Families	Interview and web-based management system

Education of adult members of the household	Number of years of formal education of adult household members	Number of years of formal education of adult household members/ Total number of adults in the household	Increases	Families	Interview and web-based management system

Benchmark 5: Family Economic Self-Sufficiency: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Household income and benefits	Total dollar value of all household income and benefits	Home visitor will ask mothers a standard question.	At program enrollment and after one year of participation in the program	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Employment of adult members of the household	Total number of hours worked (paid hours worked + unpaid hours devoted to care of an infant)	Home visitor will ask mothers a standard question.	At program enrollment and after one year of participation in the program	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Health insurance status	Health insurance status of all household members	Home visitor will ask mothers a standard question.	At program enrollment and after one year of participation in the program	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Education of adult members of the household	Number of years of formal education of adult household members	Home visitor will ask mothers a standard question.	At program enrollment and after one year of participation in the program	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment. All indicators would be collected and reported annually for the duration of the MIECHV grant.				

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports: Indicators

Constructs	**Indicator**	**Operational Definition/Calculation**	**Definition of Improvement**	**Population**	**Data Source / Measurement Tool**
Number of families identified for necessary services.	Percent of families screened who were	Number of families screened who were identified as being in need of services /	Increases	Families	Interview and web-based management

	identified as being in need of services	Number of participating families			system
Number of families that required services and received a referral to available community resources.	Percent of families that received referrals	Number of participating families with identified need who received referrals / Number of participating families with identified needs	Increases	Families	Interview and web-based management system
MOUs or other formal agreements with other social service agencies in the community.	Number of MOUs or formal agreements with other social service agencies	Total number of social service agencies with an MOU or formal agreement that is newly established or renewed	Increases	Program	Web-based management system
Number of agencies with which home visiting provider has a clear point of contact that includes regular sharing of information	Number of agencies with which home visitors regularly communicate	Number of partner agencies with which home visitors communicate for the purpose of sharing information	Increases	Program	Web-based management system
Number of completed referrals	Percent of families that received referrals and obtained necessary services	Number of participating families with identified need whose receipt of service was verified/ Number of participating families with identified needs	Increases	Families	Interview and web-based management system

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports: Data Collection Plan

		Data Collection Plan		
Constructs	**Indicator**	**How will data be collected**	**Frequency of Collection**	**Link to CQI**
Number of families identified for necessary services.	Percent of families identified for necessary services	Home visitor will interview families to assess need.	At each home visit	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Number of families that required services and received a referral to available community resources.	Percent of families that received referrals	Home visitor will interview families to assess need.	At each home visit	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
MOUs or other formal agreements with other social	Number of MOUs or formal agreements	Home visiting agency will keep a	Annual	Reports can be generated as-needed from web-based case management system ETO for all program levels (state ,

service agencies in the community.	with other social service agencies	copy of MOUs with other social service agencies		community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Number of agencies with which home visiting provider has a clear point of contact that includes regular sharing of information	Number of agencies with which home visitors regularly communicate	Home visitor will document contacts with partner agencies.	At each communication with partner agencies.	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Number of completed referrals	Percent of families that received referrals and obtained necessary services	Home visitor will interview families.	At each home visit	Reports can be generated as-needed from web-based case management system ETO for all program levels (state , community, program-specific, site specific and by program worker). Reports will document completeness of data entry and rate for current indicator. State-level administrative reports will be reviewed on a regular basis.
Timeframe for collecting baseline data: Data collected at program enrollment over the first year of program implementation will be used as baseline data for the program. Baseline data for individual participants will be collected at program enrollment. For program measures, improvement will be calculated as compared to baseline data. All indicators would be collected and reported annually for the duration of the MIECHV grant. Data use agreements will be established with the Department of Social Services to facilitate data sharing for this indicator.				

Proposed Data Collection and Analysis Plan

Proposed Measures: Measures were chosen based on the existing data collection in place in the NFP and HFA programs. Data collection is an integral part of an evidence-based practice, and North Carolina aims to support the programs in maintaining model fidelity. Thus, we have chosen to align our data measures with the measures that the programs collect. Because the NFP and HFA projects in North Carolina will be serving a very similar population, the measurements are appropriate to the population being served by both programs.

Population: Mothers during pregnancy and in the two years postpartum, and children through the age of two will be assessed individually, and their families will be assessed as a unit. Dual language learners, children with special health care needs, parents with limited English proficiency or low literacy will be assessed with the appropriate supports, such as translated tools or interpreters.

Sampling Plan: North Carolina does not plan to use sampling. Data will be collected on all participants.

Data Collection Plan: Ongoing data collection will take place as a function of program activities. Periodic reports will be generated as needed to meet program needs for data for CQI and decision-making purposes, to report program achievements, and to facilitate local partnerships. Reports will be distributed at the state level to inform all partners of the progress of each home visiting program. Federal reporting requirements will be met, including collecting a baseline measurement at program enrollment and another measurement at one year post-program enrollment.

Data Collection Quality Assurance Plan

State of North Carolina: The Home Visiting Program Director will directly supervise data collection and implement a plan to insure the quality of data collection and analysis. At the state level, the Home Visiting Data Manager will be hired to serve as the primary administrator of measures, responsible for overseeing data collection and analysis. This person is required to have: Extensive knowledge of data management, statistical methods, and the SAS programming language is required. This includes knowledge and experience in program evaluation, data set linkage techniques, and analytical statistical methods; considerable knowledge of state and federal laws and regulations pertaining to the collection, transfer, and storage of confidential data; and the ability to communicate clearly and concisely in verbal and written forms with health professionals and the general public. He or she must have a Masters degree in public health, epidemiology, statistics or related field and two years of consultative experience in human services data management/analysis; or graduation from a four year college or university and four years of consultative experience in a human services data management/analysis. Data-related activities will occupy 100% of the data manager's time.

Local Sites: All local sites will be required contractually to collect and submit specified data using ETO.

Metrics Identification Plan: Scores, percentages, counts and rates appropriate to the measures have been selected and included in the table above.

Data Analysis Plan: Aggregate groupings according to program needs will be created by request. Some common aggregate groupings used to consider health disparities include race, gender, age, disability status and income. By filtering our reports based on sub-groups within the populations served, it will be possible to further target our efforts to achieve the best possible outcomes. As collected data is evaluated, analyses will be conducted to compare outcomes based on ethnicity and age group though with the relatively low client count, nonparametric and qualitative methods may provide more insight on differences than quantitative analysis on outcomes.

Demographic and service-utilization data plan: NC MIECHV will gather and analyze service and demographic data of enrolled families in order to assess both process and outcome measures. This disaggregated data will be analyzed at least every 6 months and brought to program leadership and the CQI team. This data will be critical for program leadership in determining program modifications and resource allocations.

Benchmark data for CQI plan: The NC MIECHV CQI plan consists of two parts, state-level CQI and local efforts. For these two parts, the collection and analysis of benchmark and construct data through a state data collection system is critical to our CQI process. A thorough discussion of how we will use benchmark data for CQI is included in Section 7.

Data protection plan: The NC Department of Health and Human Services has a secure computer network that assures HIPAA compliance through encryption, user passwords, and HIPAA compliance monitoring. Further, the Division of Public Health has specific staff, a HIPAA compliance officer that assures staff is trained and records are maintained as indicated to assure HIPAA compliance. All personnel receive required training data safety, HIPAA, and confidentiality. Programmatic safeguards include locked file cabinets and locking briefcases to keep information secure while out in the community. Signed confidentiality agreements are in place for all staff. All community home visiting programs will follow all national model program standards for assuring the security of program data it maintains For example, the NFP data portal enables programs to enter data, retrieve reports, and manage data only if they have a significant program role, successfully complete NFP training, and are approved by NFP. This system uses VeriSign 128-bit Security Encryption to prevent entry by unauthorized persons.

Anticipated Barriers or Challenges: There are significant barriers to collection of benchmarks around Child Injuries, Child Abuse, Neglect, or Maltreatment & Reduction of Emergency Department (ED) Visits. The collection of this information will rely on the legal guardian of the child signing a release to provide our agency access to those administrative data. Being able to collect assessment data at least twice a year will require ongoing engagement with a family. It is inevitable that some clients will decline services prior to program completion. Home Visitors will follow model guidelines for addressing attrition. As many data points as possible will be collected from clients to enhance matching between client and the administrative information.

SECTION 6: STATE ADMINISTRATION OF THE STATE HOME VISITING PROGRAM

The lead agency for the Program for State and Local Levels

State of North Carolina

The lead agency, as appointed by Governor Beverly Perdue, is the NC Department of Health and Human Services (DHHS). The NC MIECHV is administered within the Division of Public Health. DHHS contains many of the public agencies whose participation will be necessary in the development and implementation of a comprehensive plan including public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs. The project is housed in the Women's and Children's Health Section (WCHS) of the Division of Public Health. The mission of WCHS is *to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth*. WCHS programs place a major emphasis on the provision of preventive health services beginning in the preconception period and extending throughout childhood.

Local Sites

Geographic Area	**Lead Site**
Buncombe County zip codes 28715, 28748, 28801, 28803, and 28806	Buncombe County Department of Health (BCDH)
Lesser **Burke** County (excluding pockets of affluence in identified neighborhoods)	Barium Springs Home for Children
Northeast Central **Durham** zone (a 120 block area) in Durham County	Child and Parent Support Services, the Center for Child & Family Health.
Gaston County (38 census tracts)	Gaston County Health Department
Northampton, Hertford, Halifax and Edgecombe Counties	Northampton County Health Department.
Robeson and Columbus Counties	Robeson County Health Department
Yancey and Mitchell Counties	Toe River Health District

A list of collaborative partners in the private and public sector

State of North Carolina

The NC-MIECHV program is supported by collaborative partners at the state level, including the NC Division of Social Services (agency for Title II of CAPTA), the NC Head Start Collaborative Office, the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services, the North Carolina Early Childhood Advisory Council (ECAC), the North Carolina Division of Child Development and North Carolina Partnership for Children.

Local Sites

All local sites are required to establish collaborative relationships with early childhood system stakeholders in their communities, including but not limited to obstetrical providers, pediatric providers, local health departments, local Partnerships for Children, early intervention service providers, and local school districts.

Management Plan for State and Local Levels

State of North Carolina

The lead agency for NC-MIECHV, as appointed by Governor Beverly Perdue, is the NC Department of Health and Human Services (DHHS). NC-MIECHV is administered within the Division of Public Health.

The program is housed in the Women's and Children's Health Section (WCHS) of the Division of Public Health. The mission of WCHS is *to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth*. In addition to the HC Home Visiting Program, the WCHS also houses the Early Childhood Comprehensive Systems grant, the NC Linking Actions for Unmet Needs in Children's Health (LAUNCH), the Child Care State Nurse Consultant and the Executive Director of the NC Child Fatality Task Force. The NC MIECHV has its own Program Director, Laura Louison, who will be dedicated exclusively to this program. Ms. Louison also serves on the Early Childhood Leadership Team with other Division of Public Health staff to assure strong collaboration among other early childhood programs. The NC-MIECHV team is devoted exclusively to this program, and consists of the NFP Consultant, a Data Manager, and a Business Services Coordinator. (Attachment 3: Project Organizational Chart).

The NC-MIECHV team is supported by a contract with the National Implementation Research Network (NIRN), who have been contracted to provide technical assistance to the Division of Public Health regarding implementation of the NCHV Program. NIRN will work with key state-level stakeholders (e.g. Head Start, NCPC, The Duke Endowment, and The Alliance), as well as key stakeholders at the county level to build implementation capacity. NIRN will work with programs to develop their capacity to fully and effectively implement their evidence-based home visitation models so that the intended outcomes for children and their families are achieved.

The Governor's Early Childhood Advisory Council has agreed to be the advisory council for the NCHV Program. The Governor has called upon the North Carolina ECAC to lead the state in creating and sustaining a shared vision for young children and a comprehensive, integrated system of high quality early care and education, family strengthening, and health services that support ready children, families, and communities.

Buncombe

Buncombe County Department of Health (BCDH) is the lead agency for the implementation of NFP. The NFP is a part of the Community Health Division. The Community Health Division Program Managers meet individually with the Division Head on a weekly basis and as a group monthly. The Program Managers are part of the Leadership Team that meets every two weeks Two Human Service Planner/Evaluators support the work of BCDH programs and provide assistance in identification of quality measures, data collection, analysis and presentation.

Burke County

As the parent agency of Catawba Valley Healthy Families, Barium Springs Home for Children will be responsible for ensuring the successful implementation of the HFA expansion initiative. CVHF has an administration and staff that are well skilled and experienced in successfully implementing the HFA model. Jeannie Ownbey has been the CVHF Program Director since the program's inception in December, 1999. Jeannie is a licensed teacher with BS and MA

Degrees in Special Education from Appalachian State University. All staff received Healthy Families role specific training from a Certified HFA Training Provider and Family Support in Practice training from Barium Springs' Family-Centered Training Division.

Durham

The expansion of *Healthy Families East Durham* will be supervised by Jan Williams, LCSW, who has directed the *Healthy Families Durham* program for the last twelve years. Dr. Robert Murphy and Dr. Karen O'Donnell, both child psychologists with strong monitoring and evaluation backgrounds, will oversee the evaluation, quality assurance, and quality improvement process.The referral process at *Durham Connects* will be overseen by Jeannine Sato, Coordinator. David Reese, Executive Director of EDCI, will be responsible for community public relations, publicity, and linking other providers in the targeted neighborhood to *Healthy Families East Durham* to ensure that all eligible families are referred.

Gaston

The Gaston County Health Department will be responsible for implementing NFP in Gaston County. NFP will be conducted under the auspices of our Personal Health Services Division. NFP would have its own program supervisor, who would be dedicated exclusively to this program. Velma Taormina, MD, our Medical Director and an Obstetrician will serve as program champion, providing clinical guidance for program success. Health Director, Christopher Dobbins, MPH, would provide guidance for managing political and community-related issues, and Cynthia Stitt, interim Personal Health Services Administrator, will directly supervise the NFP Supervisor.

Northampton

The Northampton County Health Department will serve as the lead agency and assume total responsibility for ensuring the successful implementation of the program. Sue G. Gay, RN, Health Director for the Northampton County Health Department will have ultimate responsibility for the program. The NFP Supervisor will report directly to the Health Director as well as the Clinical Nursing Supervisor and supervise the four home visitors and the administrative staff. Northampton County Health Department will house the NFP Supervisor, the administrative staff and one of the four home visitors. Each of the other three home visitors will be located in the other three Health Departments. Support will be provided to the staff and the program by lead staff from the respective health departments.

Robeson County

The lead agency for the program will be the Robeson County Department of Public Health. The Robeson County Health Department will administer the NFP program and serve to monitor the quality of clinical and supportive services that are a part of the model. The NFP nurses will be employees of the Robeson County Health Department but serve the Columbus County area. As employees of Robeson County, all cost will be covered by Robeson County Health Department. Columbus County will provide office space at no cost for the nurses and space to store the needed supplies and equipment for the program. Program supervision will be provided by Robeson County staff. A Columbus County Supervisor will be identified as the Columbus County liaison for the NFP staff who works in the Columbus County Health Department. This person will collaborate with the Robeson County NFP Supervisor to assure that the Columbus

County NFP staff are fully integrated into the Columbus County Health Department and assist in making linkages with other agencies.

Yancey-Mitchell

Toe River Health District (TRHD) is the lead agency for the implementation of HFA in these counties. TRHD will enter into contracts with other partners that have different areas of expertise and will be responsible for assuring that the terms of the contracts are met, terminating contracts if necessary and locating new resources to ensure desired outcomes. The Toe River Health District (including both Yancey and Mitchell County Health Departments), Yancey County Child Advocacy Center, Mitchell-Yancey Partnership for Children, and Barium Springs Home for Children will work in a mutual collaboration to provide supervision to the HFA Program.

Plan for coordination of referrals, assessment, and intake processes across models

While the NCMIECHV Program currently is only funding one home visiting model per community, there may be a number of other family strengthening programs in existence within the communities that may be funded with a combination of public and/or private funding. Possible other programs include: Pregnancy Medical Home and CC4C, care management services provided for pregnant Medicaid recipients and Medicaid and non-Medicaid children birth to 5 years of age who are determined to be at high risk; Adolescent Parenting Programs; Strengthening Families programs; Incredible Years programs, or other home visiting programs, including HFA, PAT, Early Head Start/Home Based Option, or NFP. If communities have more than one home visiting program, they are required to have a central referral, intake, and triage process to assure that families are directed to the most appropriate family strengthening services based on the strengths and needs of the family and services available in the community. In addition, funded sites are encouraged to work with all early childhood service agencies in the community to develop an early childhood system of care for families and young children.

Identification of other related State or local evaluation efforts of HV programs

State of North Carolina

The Alliance for Evidence-Based Family Strengthening Programs (The Alliance) is a collaborative network of public and private funders who support the replication of specific evidence-based programs for children and families across NC. Alliance members are committed to funding programs that have strong track records of producing results for children, families, and communities, and to funding the needed infrastructure for quality implementation of those programs. While the members of the Alliance individually fund a range of diverse programs and services across NC, the Alliance is now collaboratively supporting three evidence-based programs (EBP) with the goal of statewide replication. These programs are: the NFP (NFP), the Incredible Years (IY), and the Strengthening Families Program (SFP). The Division of Public Health houses the Evidence-Based Family Strengthening Programs Program Coordinator, but it is unfilled and frozen due to state hiring prohibitions. The Executive Director of the Child Maltreatment Prevention Leadership Team (CMPLT) has, in the interim, taken the lead on parenting programs.

Buncombe

The NSO and University of Colorado Prevention Research Center for Child and Family Health has chosen Buncombe NFP as one of 3 research sites in the nation to implement the second feasibility wave of a research based curriculum known as Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE). Buncombe was selected as a site due to the strength of the program and capacity of the Supervisor and nurses to implement a rigorous research design.

Burke
None to report.

Durham
In 2002, the Duke Endowment funded the Durham Family Initiative (DFI; P. I. Kenneth Dodge, Ph.D.). DFI involves a number of family, neighborhood, and policy level interventions aimed at facilitating the healthy development of children and families, thereby reducing child maltreatment. The evaluation of the effectiveness of the *Healthy Families Durham* is one component of that initiative designed to develop effective strategies for reducing maltreatment that can be disseminated to other counties in North Carolina, if successful. The specific aim of the evaluation is to test the existing *Healthy Families Durham* model for effects on child and family functioning, positive family support for the child, knowledge of child development and needs, and the prevention of child abuse and neglect. The study is progressing as planned. A total of 428 pregnant women were referred to the program, and 343 (6 of which were withdrawn after consent, so current accrual=337) consented to be randomized. Participants were randomized by English speaking and Spanish speaking groups. All of the birth assessment, year 1 and year 2 assessments have been completed. The final evaluation, when the participating child is 3 years will be completed in the first quarter of 2012. The data will be evaluated to determine whether the home visiting program is associated with less child maltreatment and whether the child and child/parent relationship is improved by the program.

Gaston
PAT, the only current home visiting program in Gaston County, uses the curriculum-specific evaluation, "Born to Learn Parent Knowledge", which asks 32 questions and is administered at the beginning and end of the first year of program implementation. The Cooperative Extension also administers a questionnaire from the North Carolina Partnership for Children, the program funder, to count referrals made for participants and their acquired knowledge and skills.

Northampton
The PAT program has an evaluation component mandated by the funder and the sponsoring organization. Locally, Smart Start requires data collection for all funded programs that is consistent with their Performance Based Incentive System. PBIS is a comprehensive collection of 24 population-level indicators that track health conditions for young children. Additionally, specific programmatic tools were required for outcome evaluation and quality improvement.

Robeson
None to report.

Yancey-Mitchell
None to report.

Job descriptions for key positions, including resumes;
State MIECHV Team *(See also Attachment 4)*
The ***Program Director*** is responsible for new site development and community planning to ensure that all local communities who plan to implement EBHVP have the knowledge, skills, tools, and support needed to sustain the program and build strong teams. The Director is responsible for fiscal and program oversight, evaluation monitoring, budget management and contracts administration. A resume for Laura Louison, MSW, MSPH, Program Director is included in Attachment 4.

The ***NFP State Nurse Consultant*** is responsible for clinical oversight to local NFP sites and policy and workforce development. This position ensures that all nurse-home visitors and their supervisors are prepared and supported in delivering NFP, with fidelity to the model, to diverse communities and families and helps local teams interpret client data for quality improvement.

The range of duties for the ***Business Services Coordinator*** includes administrative and program support, budget management, program marketing, customer service, event planning report writing, summarizing/reconciling information or financial data, record management, data review, and contract service monitoring and training for local staff. This position will be supervised by the Program director.

The ***Home Visiting Data Manager*** is responsible for performing collecting and complex statistical analyses of data from a wide variety of sources including but not limited to the State and National Home Visiting Benchmarks/Constructs, BRFSS, the National Early Childhood Home Visiting Survey, and CMIS data. This data will address all age groups, racial/ethnic groups, socioeconomic groups, geographic areas, and key environments in which families receiving MIECHHV services are provided. The position will be supervised by the NC MIECHV Program Director and work closely with the Best Practices Unit.

An organization chart.
See Attachment 3 for an organizational chart.

Plan to meet legislative requirements
State of North Carolina
As lead agency for the NC MIECHV, the Division of Public Health will work to meet legislative requirements for the NC MIECHV by placing highest priority on conducting home visiting models with fidelity, delivering high-quality services, and assuring we achieve Federal program expectations. To achieve these ends, the Division of Public Health will: hire qualified staff; require them to complete program training as scheduled; provide the NCHV Program Director with offices for reflective practice and team meetings; recruit additional NC MIECHV staff; maintain strong relationships with program partners; collect and submit required data to the Federal Project Officer; and, assure the NC MIECHV Program Director meets program standards.

Laura Louison is the NC MIECHV Program Director position. We will assertively recruit additional staff (NFP State Nurse Consultant, Program Assistant, and Data Manager) through

the state personnel system, colleges, universities, and professional organizations in our state. We will achieve staff competency through training and reflective supervision.

Local Sites

All local sites will be contractually required to recruit competent staff, and provide them high quality training and one-to-one supervision in order to meet legislative requirements. Local contracts will require model fidelity, and sites will receive support from both the NC MIECHV team and National Service Offices to achieve fidelity.

Plan to comply with any model-specific prerequisites for implementation

During the Request for Application process, applicants that submitted an application and advanced to the second level of review via a site visit were interviewed about the prerequisites for implementing their proposed evidence-based home visiting model to ascertain their understanding and ability to comply with the model requirements. Pending final approval, the seven sites proposed for funding will each receive a contract that will include specific language regarding implementation of the proposed model based on prerequisites, implementation requirements, complying with model fidelity, and reporting requirements. In addition, NC MIECHV staff will be monitoring adherence to contract deliverables per the Division of Public Health Subrecipient Monitoring Plan. Any project that falls below minimal expectation will be reported to the model developer and will be put under a corrective action plan to be brought back into compliance. Program staff, with the assistance of the model developer/purveyor, will be available to assist the local program in maintaining fidelity to the model.

Strategies for making modifications needed to bolster the State administrative structure

DPH will both expand the state's existing infrastructure and implement new home visiting initiatives in communities where children are at greatest risk for poor outcomes. NIRN has been contracted to provide technical assistance at both the State and local level to develop a solid infrastructure that will support implementation of evidence-based home visiting programs. DPH will expand the state-level infrastructure needed to effectively support programs by hiring NC-MIECHV dedicated staff.

Any collaborations established with other State early childhood initiatives

The proposed project builds on an existing public-private initiative to increase EBHV programs across the state; it will also link this project with various state-level early childhood initiatives housed within DPH such as the Early Childhood Comprehensive Systems (ECCS) initiative, Project LAUNCH, and the Child Maltreatment Leadership Initiative. To develop an integrated infrastructure across home visiting programs, DPH will collaborate with other organizations to develop a state-wide home visitation referral triage system that aims to match families with appropriate level of services. The ECCS grant is co-located in the same administrative section to facilitate collaboration. The ECCS grant has provided support for the beginning of the Governor's Early Childhood Advisory Council (ECAC), made up of public and private early childhood agencies and organizations, and foundations that support early childhood initiatives in North Carolina. The ECAC has been named the advisory council for this grant.

SECTION 7: STATE PLAN FOR CONTINUOUS, QUALITY IMPROVEMENT

The NC MIECHV CQI plan consists of two parts: the state-level CQI effort, and the CQI processes for local sites. The collection and analysis of benchmark and construct data through a state data collection system, as described in Section 5, is critical to our CQI process. The following summary of the state CQI plan is drawn from the NC MIECHV Updated State Plan.

Part One: STATE LEVEL CQI

I. *Framework*

The NC MIECHV CQI Team is responsible for the coordination, planning, design, and implementation of the CQI plan under the direction of the NC Home Visiting Program Director. Quarterly, or more frequently, monitoring of the improvement plan will be implemented. The state team will consist of individuals and agency representatives from the NC MIECHV team, the NC State Center for Health Statistics, other key state-level stakeholders and one or more representatives from community home visiting programs

II. *Data Collection*

The CQI process will be data-driven through the analysis of home visiting benchmarks, constructs and performance measures. Process and other measures will be selected as deemed necessary and appropriate by the CQI team. Data points will be compared to desired outcomes. State and community home visiting program managers will lead their respective CQI team in the collection of data from the home visiting database and client surveys. Data will be analyzed at least quarterly and presented at CQI leadership meetings, and continuously at all other meetings.

III. *CQI Process*

The NC MIECHV team will utilize Model for Improvement and Lean process tools. State and local teams will include those who work closely with the areas of concerns.

IV. *Use and Communication of Quality Information to Make Improvements*

Reports, with findings based on improvement efforts, will be issued following CQI meetings to personnel throughout the agency. These reports will be systematically reviewed and discussed and will provide information useful for improving programs and practice. Data-driven information will be analyzed and utilized during all regular meetings at all levels of the program; from management to implementation team.

V. *Support*

To help assure the success of our CQI plan, we have built relationships with two existing organizations in the state, the North Carolina Center for Public Health Quality (NC CPHQ) and the National Implementation Research Network (NIRN). These organizations are experts in the field of quality improvement and will be utilized to provide on-going technical assistance and training to this CQI effort. The North Carolina Center for Public Health Quality (NC CPHQ) collaborates with state and local partners to provide training in quality improvement (QI) methods and tools and develops, leads, and supports strategic QI initiatives for the Division of Public Health and local public health agencies in North Carolina. NC CPHQ aims to create an infrastructure to foster and support CQI and learning among all public health professionals in North Carolina. In addition, NIRN will work directly with state and local agencies to build

capacity to use and embed continuous quality improvement processes into the standard ways of work to support quality implementation of effective strategies.

Part Two: COMMUNITY LEVEL CQI:

The NC Early Childhood Home Visiting program will assure local CQI processes through state contracting that includes required subrecipient monitoring. All local sites receiving state funds to support evidence based home visiting will be required to develop, maintain, and implement a CQI process. The sites will be required to demonstrate evidence of a functioning and effective CQI process through the submission of quarterly reports and subrecipient monitoring audits. Local sites will receive training and or technical assistance to establish and operate a CQI team from sources including NC-CPHQ, NIRN, NFP, and HFA.

SECTION 8: STATE TECHNICAL ASSISTANCE NEEDS

NC MIECHV needs or anticipates technical in the following areas:

- strategies to build a sound state and local infrastructure which support quality replication of evidence-based home visitation programs,
- development of innovative delivery strategies to implement the selected model in rural communities with model fidelity,
- adaptation strategies for implementation of evidence-based home visitation models with special populations,
- development and delivery of effective messaging and marketing to build political support; and
- integration of model-specific management information systems into a state-level data base used by DPH administrators and policymakers.

NC will need technical assistance (TA) on strategies to build a sound state and local infrastructure as well as development of a service delivery system necessary to implement and sustain EBHVPs that adhere to the fidelity of their models and also meet the unique needs of NC communities. We will require TA to develop a model for capacity building in low capacity/ high need communities to implement EBHVPs as well as to develop innovative delivery strategies to implement EBHVPs in rural communities with model fidelity. Additionally, we will need TA, as well as the consent of program developer(s) to develop adaptation strategies for implementation of EBHVPs with special populations- specifically the military and Native Americans. NC has a significant presence of various branches of the armed forces with six military installations, and has the eighth largest Native American population in the United States.

North Carolina will receive support from the National Implementation Research Network (NIRN) and the National Service Offices in these areas. The National Service Office of NFP as well as Prevent Child Abuse America (purveyor of HFA) will work with us to develop innovative delivery strategies to implement NFP and HFA in the six rural communities with model fidelity. DPH is contracting with NIRN to assist in building a quality infrastructure which has the capacity to support our home visitation continuum both at the state and local levels.

Finally, a challenge for NC will be to develop an effective marketing strategy for the expansion and sustainability of a full continuum of home visitation programs which meets the level and intensity of the individual family's needs. We have participated in a six month Frame Works Institute Study Circle and understand the need for our messaging to be systems change oriented. Continued TA in the development and delivery of effective messaging to build political support would be helpful to assure an ongoing state investment in building a continuum of evidence-based home visitation programs in NC. We are always ready to improve our planning, implementation; messaging and evaluation strategies so TA in any or all of the areas mentioned above would be welcome.

SECTION 9: REPORTING REQUIREMENTS

The NC Division of Public Health, Children and Youth Branch will provide an annual report to federal officials including the Secretary of the Department of Health and Human Services in accordance with all legislative requirements, including required dates and formatting specifications. The report will specifically address the following six reporting areas:

A. State Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;
- Any revisions to goals and objectives identified in the Updated State Plan; and
- A brief summary regarding the State's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided in the Updated State Plan. Any updates or changes to the logic model will be noted.

B. Implementation of Home Visiting Program in Targeted At-risk Communities

Six at-risk communities have been targeted for the implementation of evidence based home visiting programs. These community sites are required, through contracts with the state, to submit mid-year and year end reports. Through these site specific reports and through the development of a state aggregated implementation report, the State will have the qualitative and quantitative data necessary to address the following updates:

- An update on the State's progress for engaging the at-risk communities around the proposed State Home Visiting Plan;
- Update on work-to-date with national model developers and a description of the technical assistance and support provided to-date through the national models;
- Based on the timeline provided in Updated State Plan, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by the State or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including subcontracts with the at-risk communities;
- Update on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting programs and other existing programs and resources in those communities; and
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

C. Progress Toward Meeting Legislatively Mandated Benchmarks

The NC Division of Public Health, Children and Youth Branch, will provide an update on data collection efforts for each of the six benchmark areas, including an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, challenges encountered during data collection efforts, and steps taken to overcome them. Our specific plan on collecting benchmark data is detailed in Section 5.

D. Home Visiting Program's CQI Efforts

The NC Division of Public Health, Children and Youth Branch, will provide an update on efforts regarding planning and implementing CQI for the home visiting program as described in Section 7. Copies of CQI reports developed addressing opportunities, changes implemented, data collected, and results obtained will be provided as report attachments.

E. Administration of State Home Visiting Program

In this section of the annual report, the NC Division of Public Health, Children and Youth Branch, will provide the following updates, if applicable:

- Updated organization chart;
- Updates regarding changes to key personnel;
- Updates on State efforts to meet the following legislative requirements, including a discussion of any challenges encountered and steps taken to overcome any identified challenges:
  - Training efforts to ensure well-trained, competent staff
  - Steps taken to ensure high quality supervision
  - Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities and
- Updates on new policy(ies) created by the State to support home visiting programs.

F. Technical Assistance Needs

For this final section of the required annual report, the State will discuss any updates on technical assistance needs anticipated for implementing the home visiting program or for developing a statewide early childhood system.